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ABSTRACT

This document represents transcripts of a series of workshops presented for the staff of a long-term care facility for aged patients. A specialist in geriatric psychiatry leads the discussions, which cover topics such as the definition of brain syndrome; testing procedures; emotional and behavioral problems; and the optimal environment for the patient with brain syndrome. Nurses, social workers, therapists and other staff members participate in the discussions and provide specific case history material. The format allows suggestions based on the workshops to be implemented, and results discussed further at later meetings. Some theoretical material is presented, but the bulk of the manual contains concrete, practical information about the care of aged persons in institutions. (Author/BP)

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National Institute of Mental Health

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AGED PATIENTS in long-term care facilities

a staff manual

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Public Health Service
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AGED PATIENTS in long-term care facilities

a staff manual

Based on staff seminars conducted for
the Hebrew Home for the Aged at Riverdale by
Alvin I. Goldfarb, M.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Foreword

One of the most difficult problems encountered by those caring for the residents of long-term care institutions is posed by older residents displaying the mental impairment associated with chronic brain syndrome. Since the great majority of the elderly persons residing in these institutions display a significant degree of such impairment, their care is of the greatest importance both for the residents themselves and for the staff who must deal with them on a daily basis for an extended period of time.

The important relationships that develop between residents and staff as a result of this daily, often intimate, contact are crucial to the behavior and functioning of the resident, to the quality of life he enjoys, and certainly to the morale of the staff and the satisfaction they find in their work.

The symptoms and behaviors that impaired old persons display, however, can often be puzzling, unintelligible, and frustrating to those around them who wish to assist them. Such difficult behavior occurring in the context of, and as a result of, irreversible damage to the brain very often leads even the most highly motivated and devoted staff members to accept the much too frequent attitude that understanding and dealing with the resident's behavior are impossible and that these are hopeless, sick old people who require physical care and supervision, whose erratic behavior is to be tolerated, but who are incapable of meaningful emotional and social relationships. Even the most compassionate individuals can be frustrated and defeated by lack of understanding of the condition of those who arouse their compassion but defeat their efforts to help. Perhaps the answer lies in having compassion informed by knowledge in order to achieve a mutually satisfying interpersonal situation therapeutic for both residents and staff.

This manual reflects a strong commitment on the part of one institution to work toward such a goal. Over the past few years, the National Institute of Mental Health has had a fruitful association with The Hebrew Home for the Aged and this document is but one product of that relationship. The NIMH was privileged to assist in establishing and studying the sheltered workshops that stimulate the seminars from which this publication emanated and to provide support for the editing of the material and its publication. None of this would have been possible, however, if it were not for the imaginative and effective leadership of Mr. Jacob Reingold, executive director of the Hebrew Home. It was Mr. Reingold who recognized the need to reconceptualize the relationship of a home for the aged and its residents, to devise new and challenging programs that were often at variance with accepted wisdom, and who mobilized the resources necessary to bring them to fruition.

The knowledge, experience, and wise understanding of Dr. Alvin Goldfarb permeate the pages of this document. It is most gratifying to have available a record of the manner in which such a skilled clinician approaches the problems presented by impaired older individuals.

The contribution of Mrs. Rose Dobrof cannot be overestimated. As former associate director of the Hebrew Home she was instrumental in bringing the programs, of which this is a result, into being. She then undertook the enormous task of editing long hours of recorded tape into a manageable manuscript.

THOMAS E. ANDERSON, Ph.D.
Chief, Section on Mental Health
of the Aging

Preface

On June 23, 1966, with support provided by the National Institute of Mental Health, we initiated a demonstration-evaluation program in our infirmary section, designed to test the therapeutic value of a "sheltered workshop" program for moderately to severely impaired chronic brain syndrome patients. It quickly became apparent that although our population included in it a not insubstantial—and increasing—number of brain syndrome patients, our staff had little systematic knowledge of the syndrome, and our approach to these patients consisted largely of techniques arrived at through a sometimes painful process of trial and error.

This deficit in knowledge and skill most of our professional staff—doctors, nurses, social workers, occupational and physical therapists—brought with them, because almost without exception the curricula of their professional education had included nothing about chronic brain syndrome. And although our inservice training programs had included content about the care of brain syndrome patients, the material was rarely presented in a systematic fashion, and usually dealt with "how-to" and "What-do-I-do-next?" questions.

The workshop project made us acutely aware of our staff deficiencies in this area; and, in addition, the project required of us that we do something about these deficiencies. We were most fortunate, as we embarked on this task of staff education, to be able to call on Dr. Alvin Goldfarb, one of the Nation's outstanding experts in geriatric psychiatry.

Dr. Goldfarb is unique in his combination of theory and clinical experience. Most of the empirically tested knowledge we have about chronic brain syndrome is the result of Dr. Goldfarb's work. And always the theory is reality based because Dr. Goldfarb has always remained a clinician—seeing and helping thousands of aged patients in his own private practice and in the public and voluntary hospitals and institutions for the aged where he has served on staff or as a consultant.

We began our seminars with Dr. Goldfarb in 1968, and almost immediately staff members asked that the sessions be taped so that the material could be permanently available to them as they worked to develop and refine their knowledge and skill. Dr. Thomas Anderson, Chief, Mental Health of the Aging Section of the National Institute of Mental Health, read our seminar reports and then participated in several of the sessions. Interested in dissemination of the knowledge and experience gained through Institute-sponsored projects, Dr. Anderson urged that we find a way of making the seminar reports available to the staffs of other kindred institutions across the country.

Dr. Anderson found the way for us: with Dr. Goldfarb's approval and cooperation, an agreement was made between The National Institute of Mental Health and The Hebrew Home for the Aged at Riverdale to edit the tapes of selected seminar sessions and to publish this material as a manual for professional staffs working with chronic brain syndrome patients. We at the Home are privileged to have this opportunity to share with others the experience of learning from Dr. Goldfarb, and are grateful to him and to Dr. Anderson for making this manual possible. Recognition is due also the professional staff of the Home, who are nameless on the pages of this manual but whose commitment to their work and eagerness to learn breathed life into every seminar session and is reflected on every page.

The formidable task of editing the voluminous amount of material emanating from the seminars fell into the willing and capable hands of Mrs. Rose Dobrof. From mountains of typed script she mined out the precious ore. The consistency, coherence, and clarity that are found in these pages are a tribute to her competence, her patience, and her persistence.

Finally, neither a Sheltered Workshop program nor an investment in staff training would have been possible were it not for the wisdom and compassionate leadership provided The Hebrew Home for the Aged at Riverdale by its president, William Goldfine, and the other officers of the Home.

JACOB REINGOLD
Executive Director
The Hebrew Home for the Aged at Riverdale

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Session 1

Brain Syndrome: Definitions, Descriptions, Explanations

Dr. Goldfarb: We are going to spend our time talking together about the old people in institutions, and about how the decline in their mental and physical capacities affects the way they think and behave. I think it will probably be helpful if we talk a bit about how this process of decline occurs, about what events in the old person's life or what inherited factors seem to influence the rate and the pattern of the decline. And, of course, all of this discussion is just the prelude to our central theme; that is, to help us increase our effectiveness in caring for aged people who live in institutions, and in dealing with their psychological or emotional problems. Far too often behavior problems make old people miserable, and helping them often seems to pose an overwhelming problem to staff.

Our job is complicated by the fact that people who work with the aged differ in their understanding of the aging processes. The words they use to talk about these processes and how they label conditions, illnesses, or impairments do not always correspond. One label which is often misunderstood is *brain syndrome*.

What do these words describe or label for you? Do you have patients in this institution who are classified as brain syndrome patients? How many? Are there some on every unit? What is your guess?

Director of Nurses: I would say at least 50 percent of our patients can be classified as "brain syndrome" patients.

Nurse: On my unit—Unit 7—it's 100 percent.

Dr. Goldfarb: How are patients for this unit selected? Are these patients different from those in other units?

Nurse: They are more agitated—more disruptive on other units, so they are sent to 7 where they aren't so upsetting to others.

Social Work Supervisor: But I don't think that just because a patient is agitated means she's got brain syndrome. Sometimes there's a good reason for the person to be upset, and we just don't take time to listen and try to understand what is bothering her. And I bet there are patients in the Home who have just as severe brain syndrome as the ones we send to 7—but they're quiet and don't cause any trouble so they don't get labeled brain syndrome and put on 7. I think it depends on how exactly you're defining brain syndrome.

Dr. Goldfarb: True. You have brought up several important points. If our discussions are really going to help us understand patients and improve our care of them, we must be certain that we use the same words to mean the same thing. There are quiet, nontroublesome people whose cerebral defects are as severe as those of the Unit 7 patients, yet they may not be labeled as having brain syndrome. This alerts us to the fact that we must agree about *what* symptoms make up this syndrome, and how we, by what measures, determine the severity of the symptoms. Our

agreement on the *what* and the *how* of diagnosis and measurement is not sufficient unless we actually examine the patients we're talking about. Many persons have brain syndrome which escapes detection until we examine them because of the variety of ways in which they dissemble: they may hide it or we may ignore its presence.

The word *syndrome*, you know, refers to a group of symptoms or signs which when present as a group are indicative of a particular disease or pathologic state. Now brain syndrome consists of the following characteristics:

1. Decreases or deficits in orientation.
2. Memory loss.
3. Decreases in patient's fund of general information.
4. Decreases in patient's ability to do simple calculations.

These losses and deficits are the psychiatric or psychological reflection of what we call *brain damage*. That is, these are the symptoms or the signs which reflect something which has happened to the brain.

Before we talk about what happens to the brain that is then reflected by this cluster of mental deficits and losses, let's spend some time on the losses.

Occupational Therapist: I don't understand this business of memory loss. Most adults have some difficulty with this; I don't remember peoples' names the way I used to, and I have to jot down shopping lists or errands. I can't trust my memory to remember each item anymore. But isn't this true of most people in their 50's or 60's and up? Don't we just figure it's "old age"?

Dr. Goldfarb: This is quite true. Most of us can and do sustain pretty substantial losses in these areas before there is an impairment which suggests that our ability to deal with the normal demands on us in our accustomed roles has been significantly decreased.

Remember that we are talking about *measurable intellectual deficit* of a type which indicates the individual has come to need special care or protection. By *measurable* I mean that both the *presence* and *extent* of the loss can be ascertained by tests which we have demonstrated to be valid and reliable, in which we can have a high degree of confidence.

You raise a question about whether diagnosis of brain syndrome can be based upon our subjective feelings of loss of memory. You are right that such a diagnosis would be in error. For one thing, we are talking about losses in intellectual functioning to which "memory" is only one clue.

We say that brain syndrome is present when our examination reveals *measurable* loss of considerable severity in four test areas, not just one. In my experience, tests of memory loss are not as reliable an indicator of disability as are tests for *orientation* and *calculation*.

Can you see why these two areas might be more reliable measures of decline in functional status than is testing for memory loss or looking for deficits in general information?

Social Worker: Well, one thing would be that it's pretty hard to fake it if you don't know who or where you are. But most everyone has been in countless situations where he's had to pretend that he knows or remembers something that he's completely forgotten—or maybe never even knew—but should have. So we learn how to fake it, and I'll bet that that's one ability that many people retain—even when they're old and have brain syndrome.

Dr. Goldfarb: This is true. People can hide their defects from us, and often from themselves. The important things for us to remember are:

Brain syndrome refers to losses or deficits
1. which are psychiatric reflections of organic brain damage; and
2. which are manifested as
   a. decreases and deficits in orientation,
   b. memory loss,
   c. decreases in general information,
   d. decreases in ability to do simple calculations,
3. all of which can be hidden from us unless we look for them.

Physical Therapist: About memory loss. Isn't it true that the loss is for recent events like, What did you have for breakfast this morning? or Did your daughter visit you yesterday?—but that the memory old people have for things which happened long ago is very clear and sharp.

I don't understand why this is so, because I would think that if there is memory loss, it would be a generalized, overall loss.

Dr. Goldfarb: I am glad that you raised this question, because the answer gives us a chance to call into question a widely held theory that old persons can't remember what happened an hour ago, but can remember events of 50 years ago.

It does not seem probable that the memory loss which we say reflects real brain damage would be specific for yesterday but leave untouched the memory banks in which are stored the memories of years ago. It is true that many patients with brain syndrome seem to have mostly a problem of learning and remembering. Failure to grasp, register, retain, and to recall what is going on or experienced now leads to their failure in being able to tell us about it tomorrow or in five minutes.

It is likely that memory for both recent and remote events is impaired simultaneously and to the same degree in most patients.

Nevertheless, patients with a fund of information and a rich storehouse of memories can sustain a substantial loss and still have enough left to conceal the extent of the loss at least during an initial interview. Over time, however, the interviewer will discover that the stories of the past which the patient told during the first interview with what appears on first hearing to be a richness of detail represent the sum total of his memory for the past. All else is gone, as is the memory of yesterday's movie and this morning's activity; and when the interviewer hears the same story several times he realizes that even here, the richness of detail is more gilt than gold and there are discrepancies and gaps which he realizes are the evidence of memory loss.

This illustrates again why I say *memory loss* does not provide as reliable a measure as do *orientation* and *ability to do simple calculation*. The measure is more reliable in these two areas because, we have said, it is more difficult to dissemble in answering orientation or calculation questions. In addition, of course, we need the safety factor that a carefully selected battery of tests gives us.

Administrator: The diagnosis in our medical records is usually *chronic brain syndrome*, but you have been talking just about *brain syndrome*. Are some chronic and others not? Or is this just another terminology difference?

Dr. Goldfarb: The distinction between *chronic* and *acute brain syndrome* is an important one. By *chronic brain syndrome* we mean it is *irreversible*, because there has been *diffuse loss of or damage to brain cells* which makes them inoperative and *these*

cells cannot be repaired or replaced. By *acute brain syndrome,* on the other hand, we mean that the condition appears to be reversible, because here the brain cells are not lost but are not functioning properly; they are still present, and if the reasons for the acute process (for example, pneumonia, uremia or myocardial infarction) are treated, the bodily processes which have led to mal-support of the brain can be corrected before permanent loss or damage has occurred.

We should therefore add to our summary definition of *brain syndrome,* that it may be acute and reversible or a chronic and irreversible condition, that acute brain syndrome is signalled by the presence of illnesses or states which can interfere with cerebral functions, can yield dysfunction, and that chronic brain syndrome is a reflection of diffuse cerebral brain cell loss which can usually be confirmed by studies which reveal cerebral atrophy.

Psychologist: What are the causes of brain syndrome?

Dr. Goldfarb: We've said that the impaired functioning which we call brain syndrome always reflects organic changes in the brain. Brain syndrome is correlated with, not a cause of, brain changes. It appears to be a measure of those changes.

What kind of changes? Well, in the first place, the changes we're talking about are in the *neurons* in the *cortex* of the brain. The change may be the actual loss of a substantial number of neurons, or it may be that a large number are still there, but nonfunctional. These changes in the neurons of the brain lead to brain malfunction and it is this breakdown in brain function which is responsible for losses and deficits in the individual's intellectual functions.

Administrator: What causes this brain damage or dysfunction that you are talking about? I get the impression that at least some of it is inevitable in old age—that is, that old people are forgetful and unable to learn new things and slower intellectually than they were when they were younger because as part of the aging process, there is the loss of brain cells and consequently a decline in intellectual function.

Dr. Goldfarb: The changes we're talking about are those which take place in the *neurons* in the *cortex* of the brain. The cortex is a relatively thin, but very important layer covering the entire brain. It is like corrugated material, so that its area, if spread out flat, is much larger than the brain area it covers.

There are billions of neurons—or cells—in the cortex, and each day we live, for a variety of reasons, we lose some of them. This continuous process over the lifetime of the individual can take place without impairing the individual's ability to live in his normal environment and to deal effectively with it.

However, in addition to these gradual, not necessarily dysfunctional, losses, there are aspects of the individual's genetic inheritance or events in his life which may act as causal agents for excessive loss which leads to brain dysfunction and perhaps to brain damage. Before we list some of these, let me note that we usually speak of *multiple causes;* that is, serious impairment or loss of a large number of brain cells is usually the result of an unfortunate combination of causal factors. Seldom is the magnitude of malfunction that brain syndrome reflects the consequence of only one cause.

Now to a partial listing:

First, accidents in which there is serious injury affecting a substantial area of the brain.

Second, infectious diseases, particularly when accompanied by high fever. It seems probable that high fever does kill brain cells. Encephalitis, meningitis, scarlet fever,

and whooping cough are examples of infectious diseases likely to be linked to brain damage. These may cause decrements in cellular quantity which, late in life, may render the individual more vulnerable to losses from other causes.

Third, stresses and deficiencies of early life may act as causal agents. For example, poor health and habitual malnutrition, long hours spent in unhealthy surroundings—polluted air, for example, may result in early losses far in excess of the gradual losses which normally occur. The individual is then left with insufficient resources when the losses associated with old age occur.

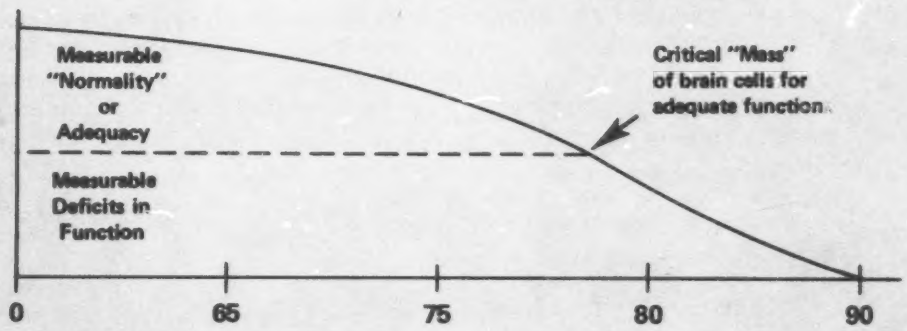
Fourth, aspects of the individual's genetic inheritance appear to predispose him to brain dysfunction or damage—for example, the condition called *senile deterioration*. Something causes a rapid loss of a substantial number of brain cells, which is reflected by the impairment in function.

Occupational Therapist: You've emphasized that the number of lost or malfunctioning cells must be large for the loss to be reflected in impaired functioning. Do we know what this number is? Is it the same for everyone? It seems to be that the highly intelligent person who continues to use his intellect in old age is less likely to become a severely impaired brain syndrome patient.

Dr. Goldfarb: Let us approach your questions in diagrammatic fashion. You asked first how many cells have to be dysfunctional or damaged in order for these malfunctions to be reflected in impairments in the individual's ability to manage for himself. Our diagram doesn't give us any answers expressed as numbers—for example, we can't say most people need 10 billion minus Y=X cells in order to escape the diagnosis of brain syndrome. There seems to be a slightly different *critical mass* for each of us. Above that point we can sustain the loss or malfunctioning of substantial numbers of cells, without noticeable impairment of our functioning. But a loss which drops our *critical mass* to a level below that figure will be reflected in deficits in our intellectual abilities. What these deficits mean is that we are no longer able to be self-orienting, particularly to place and time; perhaps we have to stop and think about the number of children we have or what their names and ages are; we're no longer sure how to figure out how much money we would have left if we had $60.00 and spent $10.00 at the grocery and $3.20 at the drug store.

Physical Therapist: Could you explain what self-orienting for time and place means?

Dr. Goldfarb: Well, all of us, I think, have had the experience of waking in the morning, and for a moment, not knowing where we are or what day it is or what time of day or night it is. Quickly, we orient ourselves: we come fully awake, look around,



perhaps glance at the clock, remember what we did yesterday or what time we went to bed last night. We may feel again for a moment the emotional texture of a dream we had during the night, and we may conclude that we were in the midst of this dream when we awoke, and our momentary disorientation came in the abrupt transition from dream to reality.

Or we may be driving home, and suddenly we look about us, and realize we have been "lost in thought," or daydreaming and unaware of the blocks we have traveled. We place where we are, and continue on our way—usually with the resolve to concentrate on our driving and forget about the fight we had with the boss and the things we should have said if only we had thought of them at the time!

In both of these quite commonplace experiences, we go through an automatic intellectual process by which we reorient ourselves for time and place. We use items in the environment—the absence or presence of daylight in the first instance, familiar landmarks in the second—to help us place ourselves in time and place. We also use our ability to recall the immediate past—what we did yesterday, or where we were in our journey when last we looked.

This is simply a description of familiar experiences which may help us picture what we do when we orient or place ourselves in time and place. It is this self-starting ability that is impaired or lost in the aged brain syndrome patient.

Nurse: It must be very frightening to the person when she realizes that not only does she not remember what day this is, but she also has forgotten the way to find it out for herself, except by looking at the paper or asking someone, or watching the "Today" show when she gets up each morning.

Dr. Goldfarb: Yes, and as a matter of fact, sometimes the changes which are seen in the behavior of old people may be the reflections of their fearful responses to their awareness of their losses and of their frantic efforts to secure from people in their environment the kind of guarantees of help and protection they will need in order to survive. A patient I saw just this morning is a good example of what we're talking about. She has been aware for some months now of declines in both her mental and physical health status and she is—not surprisingly—frightened and depressed. She and a younger sister have lived together since the deaths of their husbands several years ago.

In her fear and depression, she wants her sister to remain at her side day and night. Her sister continues to leave her to go to work each day, and my patient now insists that this sister is an impostor. Her real sister, she says, would not go off and leave her each day, and, therefore, this woman who does this cruel thing, must be an impostor who somehow has taken her own sister's place.

What we are seeing in this patient is an affective disorder in association with mental impairment, and I know from my consultations with you, that this is not an uncommon occurrence among your patients.

Nurse: Dr. Goldfarb: We have a patient in the Infirmary now, and we can't quite figure out what has happened. She showed no signs of mental impairment, and then about a month ago, she was sent to a hospital for an operation for glaucoma. She's been back a week now; she doesn't recognize any of us or even the other patients to whom she was very close. She doesn't seem to know where she is, although she's been in the Home for several years and on our unit for over a year. Did the operation cause the brain syndrome?

Psychologist: Looking at Dr. Goldfarb's diagram, I would guess that this patient was one who had had some earlier and substantial losses. But she was still doing okay because

she was still above her *critical mass* point—probably just above it, though. So the operation caused loss or damage to more brain cells—and even if relatively few were affected, because she was already close to the line, the few were enough to push her under.

Nurse: Our patient seems very frightened and constantly seeking reassurance that we're here and we'll take care of her. So this could be an example of the affective disorder you were talking about, couldn't it, Dr. Goldfarb?

Dr. Goldfarb: Yes, I would think it would be quite likely that her behavior may signal her awareness of her declining abilities, and her efforts to adapt to her losses. She may also be in the midst of an acute brain syndrome episode, and some of the confusion may recede. It will be important that we get an accurate diagnostic picture of her mental status, so that we don't mistake confusion due to the affective disorder of depression for confusion associated with brain syndrome.

In our next session we'll talk about the testing procedures we use in order to determine the presence of brain syndrome.

Session II

Testing Procedures

Dr. Goldfarb: We had agreed that we would start today with a look at the two tests or examinations which we have found most reliable in diagnosing the *presence* and *severity* of brain syndrome. We are going to spend this time on testing procedures because it's important that we are all talking about the same thing when we talk about a diagnosis like chronic brain syndrome moderate, as measured by patient performance on specified tests.

The first test is called *The Mental Status Questionnaire—"Special Ten"*—"Special Ten," because the test consists of 10 questions which the examiner asks the patient to answer. As you see, the questions and answers are brief and quite simple, and its brevity and simplicity are part of the beauty of the test.

Mental Status Questionnaire

Questions	*Presumed Test Area*
1. Where are we now?	Place
2. Where is this place (located)?	Place
3. What is today's date—day of month?	Time
4. What month is it?	Time
5. What year is it?	Time
6. How old are you?	Memory—Recent or remote
7. What is your birthday?	Memory—Recent or remote
8. What year were you born?	Memory—Remote
9. Who is President of the United States?	Memory—General information
10. Who was President before him?	Memory—General information

If the person makes 0–2 errors, we say that organic mental syndrome or brain syndrome is absent or mild; 3–8 errors, brain syndrome is moderate; 9–10 errors, brain syndrome is severe.

Now let's look at these questions which were selected from much longer lists of questions and which in test after test—administered by many different examiners—were found to be most reliable and also best at discriminating between disorders of affect and brain damage.

Social Worker: Just looking at the questions, I see one important advantage. It's easy to check the answers for accuracy. The first five and last two the examiner knows, and numbers 6, 7, 8, would be part of a fact sheet or identifying information on any applicant to or any patient in a home for the aged or nursing home. Also, this test taps three of the four areas on which the diagnosis is based. It tests for orientation, memory, and general information.

Occupational Therapist: Is the rating ever wrong? Do you ever have to modify the questions to fit a particular individual or situation? For instance, the old person living in a home for the aged or nursing home doesn't have to know today's date the way people living and working in the community do. As a matter of fact, I often don't know the date, and have to stop to look at a calendar or figure it out. When I saw the

questions just now, I didn't know today's date, but I knew that last Sunday was the 12th because it was my son's birthday, so I quickly figured: Sunday was the 12th, so today, Tuesday, has to be the 14th.

Dr. Goldfarb: All right, now what you've just done is an example of what we talked about in our last session. It is not unusual for some of us not to be sure all the time of today's date, and this does not mean that our functioning is impaired, because we can immediately engage in a process of *self-orienting*. Last time we talked about how we place ourselves when we awake in the morning or after a period of being lost in thought, and today you went through exactly the same kind of intellectual process in order to figure out today's date. You used your memory of recent events—the Sunday birthday—and your ability to reason and calculate: if Sunday was the 12th and Monday was the 13th, today, Tuesday, then has to be the 14th.

Remember, we said that the organic mental syndrome patient does not know exactly where this place is or what day or month or year this is; and in addition, he can't remember how to figure out the where and when questions.

You're probably right that there's less reason for people in an institution to know today's date. I find that when I'm on vacation, one of my greatest pleasures is my freedom from the tyranny of the calendar. It's so nice not to have to worry about today's date and agenda; and similarly, perhaps, this may be one of the more pleasant exemptions which come with old age and retirement—the freedom not to have to re-orient oneself to day and date each morning.

So when one of your residents doesn't answer question 3 correctly, it may not in itself signify impairment as would an incorrect answer to the question from one of us. Remember that the *"Special Ten"* is not the only test we use. We expect to see a high correlation between the patient's scores on different tests, if they are valid. The absence of such a correlation would alert us to possible situational factors—like institutional life—which are distorting results.

Let us therefore, look at the second test which we use in combination with the *"Special Ten."*

Again the test is brief and the procedure is simple, and the results are valid; that is, errors usually reflect the existence of brain damage in adults. For the *Face-Hand Test*, the examiner and patient sit facing each other, and the patient is asked to put his hands on his knees and his feet flat on the ground, and to close his eyes. The examiner simultaneously touches the patient's cheek and hand, and the patient reports—either by word or sign—where the touches were.

The test procedure is one of double-simultaneous stimulation, usually in this order:

1. Right Cheek—Left Hand
2. Left Cheek—Right Hand
3. Right Cheek—Right Hand
4. Left Cheek—Left Hand
5. Right Cheek—Left Cheek
6. Right Hand—Left Hand
7. Right Cheek—Left Hand
8. Left Cheek—Right Hand
9. Right Cheek—Right Hand
10. Left Cheek—Left Hand

If the patient makes errors, the examiner tells him to open his eyes, and then repeats the test. In most cases, there is little or no improvement in the retest. And when a patient does poorly on the *"Special Ten"* and also makes errors on this

test, I find the similar scores on the two tests are almost always accurate measures of organic mental syndrome.

Director of Nursing Services: There's a lot of work in that test for someone who is not as sharp as he used to be. He has to accept the testing situation, with all the fears that most of us feel when we're being tested. And he has to close his eyes—which must make it worse—and follow a series of instructions:

- sit down
- hands on knees
- close eyes
- wait until the examiner touches you
- report to the examiner where the touches are

I imagine that some of our patients don't do well because they won't be able to remember what it is that they're supposed to be doing. You know, by the time the patient's all settled in the chair and his eyes are closed and his feet are flat and his hands are on his knees—all of that will have been too much for him to deal with, and he'll either get angry and refuse to go on, or he just won't be able to remember to do what the doctor told him to.

Dr. Goldfarb: You're right, of course, so that if we get an aged patient who is untestable in the way you've described, we can be pretty certain that he's untestable because his brain is so damaged that he can't grasp the testing situation or understand what he's being asked to do.

Chief Occupational Therapist: But what about the patients who are testable? How does this test work? If the patient answers incorrectly, is it that the messages from the cheeks and hands are not processed correctly by the damaged brain? Are they sent to the brain, but don't register in the brain; or the brain gets the message, but doesn't understand it or doesn't know how to report it?

Dr. Goldfarb: In the case of this test, its simplicity masks what is really a quite complex test. As we've seen already, we test the ability of the patient to grasp the testing situation, to understand instructions, and then to remember them—all of this in the framework of testing and evaluation, which is in itself a troublesome kind of situation.

In addition, this is a perceptual task—that is, a test of the ability of the brain to receive a sensory stimulation and from that sensory experience to derive knowledge of the external world. This double, simultaneous stimulation is a very good test of the brain's capacity to perform the *task of perception.* And if the brain can't do this—can't receive the message from the sense of touch and understand what has happened in the external world that has created that sensation—then we say that the inability must reflect damage to the brain.

Or to put it in a different way: If we have given a patient a superficial once-over and think that there is probably brain syndrome, or if the family or other staff report changes in the patient which are suggestive of brain syndrome, and if we find on administering this test that the patient is able to report the stimulations accurately, then we should assume that other factors may be preventing our patient from making maximum use of his resources. And we can feel more optimistic about the possibility of improving his functional ability if we can get

at the other, nonorganic factors. This, of course, should remind us that we use a battery of tests and observations—not just one—in making our assessment, and that the several tests and comparisons among them constitute a safety factor for us, increasing the likelihood of accuracy and avoidance of error.

Social Work Supervisor: I think, Dr. Goldfarb, that in explaining to us what the test measures, you've put your finger on one of our most difficult problems: We have a resident or patient whose behavior is troublesome to herself and to other residents and to staff, and we don't know whether she's behaving this way because of her impaired intellectual abilities or whether the trouble is more emotional-functional, rather than organic. And to tell you the truth, Dr. Goldfarb, I'm not sure that even if I knew which it was, that I would also know what that means—what difference it makes in how staff works with the resident.

Dr. Goldfarb: I'll make this our starting point for the next session. We've defined brain syndrome and we've talked about testing procedures used to diagnose its presence and severity. Next week, let's talk about emotional disorders of the aged—those in association with brain syndrome and those independent of it.

Session III

The Emotional Disorders and Behavioral Problems of the Institutionalized Aged: A list of some of these and discussion of "Mrs. Overly Dependent"

Dr. Goldfarb: This session is to be a beginning of our discussion of the kinds of emotional problems and behavioral disturbances that we see among the residents and patients with whom you work. Let's start by listing and describing the kinds of problems or behavior that you find most difficult or that you don't feel you understand.

Nurse: I'd like to ask about a specific kind of patient that upsets me—that's the patient who says things to you like:

"When you're not here, I'm so lost I don't know what to do."

or

"Walk down the hall with me; I can't go by myself."

or

"Who will take care of me if you go away?"

It's not flattering to me; sometimes patients like this torture me on my day off, because they are angry and hurt when you leave, and you can't help but worry about how they'll be without you.

One of the other nurses has a patient who tells her she doesn't have a bowel movement on the nurse's day off. As I said, this isn't flattering; they become so dependent on you that it's harmful to them. Your goal is to help them be as independent as possible. But that isn't what they want. They make you feel like a mother; and when you go away, it's like a mother abandoning her children.

Social Worker: I brought the report of my last Men's Club Meeting because what happened at that meeting is an example of a problem which seems to be on the increase in the Home, and none of us is very satisfied with the way we handle it.

The meeting was over, and we were sitting around the big table drinking our coffee. Mr. White and Mr. Block were sitting next to each other about two seats away from me. I was listening to a story the man who was sitting next to me was telling, and I heard Mr. Block tell Mr. White to be careful of how he held his cup, because the coffee was hot, and Mr. Block said he didn't want Mr. White to spill it and get burned.

Right after Mr. Block said this, Mr. White suddenly jumped up and started screaming at Mr. Block and hitting at him with his cane. The rest of the men were in a panic; Mr. Block was trembling in his chair. I got up, and went over to Mr. White who was yelling that Mr. Block had tried to get him, and now (to me), "You're after me, too."

I finally got Mr. White out of the room and back to his Infirmary floor. When I got back, the men talked about how you had to watch out for the ones who are crazy. Some of them criticized the Home for taking people like this into the Home, and others thought that staff should be more active in preventing attacks like this, and also that the attacker should be publicly chastised.

That's the end of my report. I don't know what we should do—for Mr. White or for the other residents who seem to be asking the staff to handle this problem and protect them against physical attacks.

Chief Occupational Therapist: We had a situation in our department a couple of weeks ago which seems somewhat like the problem of Mr. White and Mr. Block. The behavior is different, but it involves patient attitudes toward behavior they don't like . . . and the staff had questions about what they should have done. As I reported:

> Most of the patients were working when suddenly there was a commotion at one of the tables. I went over; Mr. Kaye had pushed his chair right next to Mrs. Gordon. He had his hands on her, and his fly was open. She was just kind of sitting there, but Mrs. Silver and Mrs. Brown—who were on the other side of Mrs. Gordon—had seen what was happening. There was a great deal of commotion. Mrs. Silver had gotten up and was yelling at Mr. Kaye and trying to pull him away. Mrs. Brown was calling for staff, and the other residents were getting up from the table, and there was a lot of confusion.
>
> I told Mr. Kaye to move himself and his chair back where they belonged, and told everyone else to sit down, and Mrs. Silver and Mrs. Brown I shushed. Meantime, one of my staff had called the nurse on Mr. Kaye's floor, and an aide came immediately and took Mr. Kaye back to the floor. Mrs. Gordon seemed unaffected by what had happened; she had been doing some weaving and she went back to work. Mrs. Silver and Mrs. Brown were still talking about how terrible Mr. Kaye was, and that if it hadn't been for them, goodness only knows what might have happened to poor Mrs. Gordon. Particularly Mrs. Silver, I think, was angry at me for telling the two of them to be quiet, and I suppose for not giving them recognition for what they had done. And just like in the Men's Club, these ladies said a man like Mr. Kaye shouldn't be allowed in this Home, and nice people like themselves should not have to live with "such filth."

Dr. Goldfarb: You are right that the two situations have much in common. We want in both cases to understand why the individual is behaving in this way, and we want to look at how we can help him, and also how we can help the other residents who seem to feel that the Home is not doing everything it should.

Let's take the three questions or problems and see if we can come up with some ideas about old people and why they behave as they do. Let's begin with our overly dependent lady because I think discussion of her will help us understand a number of things. Mrs. Stone tells you that she feels lost and afraid when you aren't there. Do you have any reports from staff about how she actually does when you're off duty?

Nurse: She manages all right most of the time, I think.

Dr. Goldfarb: But if this is true, then why do you think she says what she does to you?

Nurse: Well, I've been on the floor for almost 2 years. The people know me and trust me. They're frightened when they don't see a familiar face—not just me.

Dr. Goldfarb: And what do they think telling you about these feelings will accomplish? Will it make something better?

Nurse: They probably want to make me feel sorry for them.

Another Nurse: They're ingratiating themselves with her so that she'll continue to like them and be nice to them. If she's so special to them, she must reciprocate and feel that they are special to her.

Nurse: Well, it upsets me. Just before I came to today's meeting, Mrs. Stone said that she couldn't walk to the dining room by herself. I told her that I knew she could—that she should hold onto the rail and that I would watch her. She did; she knew I was there watching her. I can't walk down the hall with her all the time. If I let her hold onto me all the time, she'll become so dependent it won't be good for her.

Dr. Goldfarb: Is she able to walk when you're not around?

Nurse: I guess so. I don't hear that she's not. Her vision is failing and she has to go slow and most of the time hold onto the rail, but she really doesn't need the rail and me, too. She's no more infirm than a lot of patients who get around without having to be helped all the time.

Dr. Goldfarb: Now we have two examples of our lady saying she can't manage without you. Yet there are no reports of her not being able to get about when you're not there. Also, Mrs. Stone doesn't seem to be functioning as well as we think her health status should permit. Other people, similarly impaired, seem less disabled than Mrs. Stone—more able to use the resources remaining to them. She is, in a way, complaining excessively, in words and by her actions and behavior, she is troubling to you. She wants you to worry about her, even though you know that others share in her care, even though you try to put the job out of your mind when you're off duty. You worry also because you're afraid that if you somehow encourage—or maybe it's don't *discourage*—the patient's dependence on you, she will become increasingly dependent and increasingly unable to make use of the resources and strengths which remain to her.

Let's go back to what we know about this lady and how she feels about herself and about people around her. What was she like in the past?

Social Worker: I was Mrs. Stone's social worker when she first came into the Home, just about 3 years ago. She was a clutching and demanding kind of person, terribly scared that she couldn't take care of herself and scared, too, that people wouldn't help her, do for her. She seemed to be frantically trying to reach out and somehow bind people to her.

I remember thinking that nothing was enough—no matter how much you did, it didn't seem to convince her that we really are here to help her. I always thought that part of the problem was that her daughter rarely came to see her or called her. Her one son came on duty calls once a month and on her birthday and on Mother's Day—that kind of thing—and always alone; his wife and kids never came with him. The one person who seems to feel affection toward her is the other son's wife, but they live in Chicago, and so there are limits to what they can do for her. The Chicago daughter-in-law writes to her at least once a week, and they call her once a month regularly.

And, of course, as her health got worse, I guess she got more frantic about who was going to take care of her. She never participated in any of the activities, although we tried over and over again to get her interested in something.

And she didn't make many friends: she didn't seem able to talk or think about anything except herself and her complaints! And the other residents got tired of listening to nothing except gloom.

Physical Therapist: That jibes with my picture of her, particularly the fact that no matter how much you do for her, it doesn't really seem to make any difference. She's the kind of old person who seems most tragic to me. Nobody can stand being around her

for long, because she is so clutching, and because she makes you feel so lousy about not being able to do everything she wants. And then—I hate to say it—but you end up angry at her because you have tried to help, and all she does is complain.

Nurse: I have Mrs. Stone's medical record here.

On the brain syndrome rating, she was examined twice: once during our intake examinations, and again this year as part of the routine semi-annual. She was rated chronic brain syndrome mild the first time, and this time, 2 years later, rated in the low end of the moderate range. She's really pretty intact, compared to a lot of other patients on our floor.

Occupational Therapist: You know, Dr. Goldfarb, during our second session you talked about how frightening it is for some people when they become aware that "they're slipping." You said that they sometimes start a frantic kind of search for guarantees from people that they'll be taken care of, and that some of the behavior we associate with old age is not the aging process, so much as it is a symptom of the person's terror—her feeling of being helpless and alone. Isn't this the explanation for Mrs. Stone's overly dependent, clutching behavior?

Dr. Goldfarb: Yes, this does seem pretty clear, doesn't it? Her health status, both physical and mental, is on the decline, and her disabilities in some very important areas of function—sight, hearing, walking—are increasing. And she sees these losses in her ability to manage for herself and get what she needs, and she is very afraid.

Nurse: But, Dr. Goldfarb, what is happening to Mrs. Stone is par for the course among our residents: their declining health and increasing inability to cope with the demands of living on their own is what brings them to the Home. But not all of them respond to this the way Mrs. Stone does; a lot of our residents much more disabled than she are pretty cheerful and interested in other people and not clutching at everyone and complaining the way Mrs. Stone does. And as we said before, there are patients just as infirm as Mrs. Stone is who get around better than she does. I don't mean that she's the only one; there are plenty like her here in the Home, but there must be special things about these people that account for their inability to cope with the losses of old age.

Dr. Goldfarb: An excellent point, and exactly the subject which I had hoped we would get to in this discussion of the many "Mrs. Overly Dependents" among our residents and patients.

I have a hunch that many of the patients and residents in homes for the aged and nursing homes are people like Mrs. Stone. As you point out, people enter these homes because the losses they have sustained in old age have left them unable to manage for themselves. But we know that for every resident or patient in nursing homes and homes for the aged, there is an equally aged, equally infirm person still living in the community—somehow, despite no more obvious resources. How is it they are better able to use what they have than our overly dependents?

I think that the way in which a person responds to changing circumstances in old age is determined not only by present circumstances and his expectations but by several identifiable factors in early life. Our "Mr. and Mrs. Nondependents" are people who were probably raised in homes where there were capable adults with whom they could identify. They were socialized so as to assert themselves; they were not overly intimidated and inhibited, and they developed feelings of self-esteem which rested on their own achievements, rather than on their ability

to make use of their parents' strengths. In the process they developed self-confidence based on their ability to realize their own accomplishments, and also a sense of purpose which was their own for their own lives.

"Mrs. Overly Dependent," on the other hand, was raised by parents who did not so much encourage the development of self-reliance as they encouraged, directly or indirectly, reliance upon parents. Children who are socially, physically, emotionally inhibited, who are overly restrained in their development, may feel the need of parents to help them get what they need and do what they should.

Nurse: I don't understand how all of this explains Mrs. Stone. She certainly isn't doing what we ask her to do to please us; she's trying to get us to do what she wants us to, whether we want to or not.

Dr. Goldfarb: All right, let's see if we can trace the path from the child who acts in order to please her parents to our overly dependent Mrs. Stone. Let's take our nondependent and overly dependent children again, and let's look first at the word we've been using—*dependent* or *dependency*. What does it mean?

Physical Therapist: Well, it's a *need*—a need for assistance, for instance.

Dr. Goldfarb: Look at it as a verb for a minute. You can't just say *"I depend"*—that's not complete, is it? What other words do you need for it to make sense?

Recreation Worker: It's always depend *on* something; like Mrs. Stone depends on the nurse or I depend on my own two feet to get me here every morning—or, well, there are lots of examples, but it's always depend on someone or something else.

Dr. Goldfarb: So *dependency is always a relationship* involving two people or a person and an object. For instance, I depend on my car to get me to work. Now, what or who is our overly dependent child being taught to depend on; that is, what or who does she need in order for her to feel happy or satisfied or at ease?

Social Worker: I see what you mean, I think, Dr. Goldfarb. She can be proud of herself only if she makes her parents proud of her, and the only way to do that is to do what they want her to. So the right thing to do is what Mother and Father wants, and the important question always is, Would they approve? There are people who are always seeking approval; they never do anything unless they're sure it's what other people will agree with and like them for. You can never count on them to believe in or act on principle for its own sake. They'll promise you they'll do a certain thing or vote a certain way, for instance, and then if someone whose approval means more to them than yours does comes along and asks them to vote against you or not to do what they had promised, they'll switch in order to please that person.

Dr. Goldfarb: All right, now go back to the question: What is it that this person is going to need in order for her to feel that life is going pretty well? On what is she going to be dependent?

Occupational Therapist: She's always going to need other people who love her and approve of her. But Dr. Goldfarb, don't all of us need other people to whom we're important and who understand and love us?

Recreation Worker: Yes, but some people need so much love and recognition that it seems they think that they're nothing without it. You see it among teenagers, for instance—the kid who can't bear the thought that someone might not like her, or the execu-

tive who can't fire an incompetent because he wants everyone to think he's a great guy.

Dr. Goldfarb: And underneath it all, how do you think this kind of a person feels about himself? How does he assess his ability to get along and to do pretty well?

Nurse: I see the connection to Mrs. Stone. She feels very weak and frightened and helpless; she thinks she's nothing on her own—she says it: I can't do anything without you, so by hook or by crook, I've got to be sure you'll help me. I'm weak and you're strong, and if I have you, I don't have to be afraid.

Administrator: You know, while you were talking, I was thinking of another patient, Mrs. Fisch. Would you all agree with me that she's a "Mrs. Nondependent"? Well, contrast her with Mrs. Stone. Mrs. Fisch is certainly as infirm as Mrs. Stone, and since she has no children, or close family who could care for her, she is, in a way, more dependent on us than is Mrs. Stone who has children—whether they love her or not.

Yet I rarely hear Mrs. Fisch complain about loneliness, and she's certainly always busy and involved. And when she needs something, she isn't afraid to ask. You know she requested a single room in the new building; she didn't demand it, and on the other hand she didn't butter us up before she made the request. She feels—and rightly—that she has worked hard in the Home, and that she merits a reward if rewards are available, as in this case. But she didn't work for the reward. By that I mean, she does the things she does for their own sake—because she's always been this way, and she'll continue, regardless.

But when the new building opened and there were a certain number of single rooms, she wanted one and was not afraid to assert herself. She felt confident enough about herself and about us to let us know that she felt she deserved a single room and that we wouldn't hate her for her assertion of her claim.

Even with her disabilities, she still feels able to deal with things; she doesn't feel helpless and weak. Even when she was—remember when she fractured her hip a couple of years ago? She still didn't feel helpless the way Mrs. Stone does—I guess because Mrs. Fisch knew that we would help her. But poor Mrs. Stone, no matter what we do, as you said, it's never enough; we can never convince her that we won't abandon her.

Dr. Goldfarb: And now, I think we can pull some of this together, and continue this discussion in our next session. We've traveled a winding and perhaps not always clear path from our beginning where we made a list of the questions and problems we have in understanding what makes our aged patients and residents act the way they do. Mrs. Stone was presented as an example of one kind of patient who presents very special relationship and management problems to those around her. We have labeled her—correctly, I think—"Mrs. Overly Dependent." We've seen her as someone who is very aware that she is not as healthy now as she was a year ago, for example, and that she is not able to do for herself as she once did.

This, as several of you have pointed out, is happening to many of our residents and patients; some of them like Mrs. Fisch seem able to cope with these losses in an effective and graceful fashion. I have said that I think that Mrs. Fisch and people like her come into old age as relatively nondependent people, as people whose self-confidence and self-esteem are strong enough so that they are not destroyed by the losses and infirmities of old age.

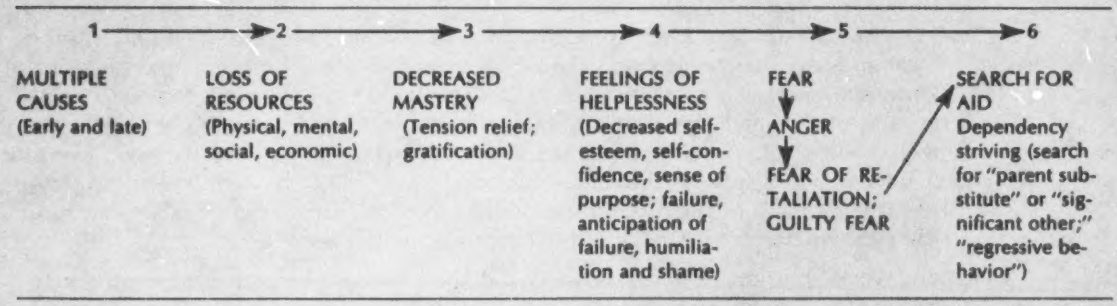
But Mrs. Stone and many other overly dependents like her are different. When they find that they can no longer do all the things that they used to do, they feel

helpless. Their feelings of self-esteem and confidence were always contingent on the belief they need others to depend upon. Now as they are no longer able to do the things by which they believe they gained this value with regard to "Important Others," they feel that they are, therefore, failures, and they feel ashamed of their failures.

Their helplessness may lead to fear. You've described how fearful Mrs. Stone was when she first came into the Home, and you've also described how much worse her feelings of fear and helplessness are now in the face of declining health and increasing infirmity.

You've talked about the way she clutches at staff people and of her great open dependency on you, and of her efforts to bind you to her. A diagrammatic presentation of these psychodynamics helps to describe the situation of Mrs. Stone and many other of our patients and residents.

COMPONENTS OF DISORDER: PSYCHODYNAMIC SEQUENCE


1
2
3
4
5
6
MULTIPLE CAUSES (Early and late)
LOSS OF RESOURCES (Physical, mental, social, economic)
DECREASED MASTERY (Tension relief; gratification)
FEELINGS OF HELPLESSNESS (Decreased self-esteem, self-confidence, sense of purpose; failure, anticipation of failure, humiliation and shame)
FEAR
ANGER
FEAR OF RETALIATION; GUILTY FEAR
SEARCH FOR AID
Dependency striving (search for "parent substitute" or "significant other;" "regressive behavior")

1. Multiple causes or initiating factors which occur either early in life and are reinforced or modified with aging or occur late in life and are peculiar to old age, several of which may combine forces and some of which may be necessary but insufficent alone, result in
2. An absence or loss of resources for minimally, adequate functioning, so that
3. There is a decreased mastery of problems, challenges, and adjustments posed by internal changes (biologically determined drives or acquired needs) and external changes and threats, with resulting
4. Feelings of helplessness or actual powerlessness, and consequent
5. Fear with accompanying or subsequent anger, with consequent
6. "Rationally" or "irrationally" aimed and elaborated search for aid which becomes patterned in terms acceptable to the individual in terms of his personality organization based upon his past. his present, and his expectations; and contingent on his perception of what is acceptable to and likely to work in "his world" as well as by the social response it receives. In this search there are observable constellations of motivated personal action which range from apathy through pseudoanhedonia, display of helplessness, somatization, hypochondriasis, depression, and paranoid states to the most open and manipulative behavior. In predisposed persons there may be a physiologic shift to a new and relatively inefficent homeostatic level with depressive states which are then revealed by altered appetite, bowel function, sleep, and other vegetative signs.

Session IV

"Mrs. Overly Dependent"—Continued, with a Second Look at Our Response to Her; and Discussion of Mrs. Harris, A New Resident

Nurse: Dr. Goldfarb, I have been doing a lot of thinking about my relationship with Mrs. Stone, and about our discussion of her during the last seminar. I had told about how she tells me that she is frightened and lost when I'm not on duty, and you asked me what really happens when I am not here. Of course, I know that other staff are here and they do their jobs, and that Mrs. Stone is really no different whether I am on or off. And then, you asked whether I knew why Mrs. Stone was telling me how lost she feels without me. I said that the people on the floor know and trust me, and feel insecure when familiar staff is not there. Of course, that didn't answer the question you asked me.

You hadn't asked me, Why does Mrs. Stone feel lost without you? If that had been the question, my answer about how the patients know and trust me would have been right. But you wanted to know, *not why she feels this way, but why she says this is the way she feels when I'm gone.* So you asked me again, What is Mrs. Stone trying to accomplish by telling me this?

This time, I heard your question. I said that she was trying to make me feel sorry for her; and that really got us into the whole discussion of Mrs. Stone as a person who feels helpless and absolutely dependent on other people. I understand that her self-esteem and self-confidence are zero, and so she doesn't feel that other people will really want to help her, so she has to manipulate and control them so they have no alternative except to help her. And that is her purpose in telling me I'm the only one.

But the thing I realize now is that Mrs. Stone isn't the only one whose self-esteem is dependent on the approval of others. I said last week that I wasn't flattered when she tells me that I'm the only one who really understands and helps her, but that isn't altogether true, I guess. I wasn't comfortable when you kept asking me how she does when I'm gone . . . and what she's trying to accomplish by telling me how much she needs me. I do know that she doesn't fall apart when I'm not here; yet I do feel guilty when I leave her for my day off, and I do have to steel myself against that guilt and against worrying sometimes about whether she's okay when I'm off.

And that's not logical. The other nurses—not just on my day off, but the ones on the other two shifts who are regular just like me, so Mrs. Stone knows them as well as she knows me—these other nurses are good professionals. They do their job, and I know it— yet I act as if I don't. When I feel guilty and worried about her, I'm acting as if what she says is true—that I'm the only one who really helps her. And I guess it's because, without my realizing it, I did feel that her need for me proved what a good nurse I am. So that's why I say that it must be that I need her approval in order to boost my self-esteem. So both of us need each other in ways that aren't so good.

Dr. Goldfarb: This hasn't been easy for you, and yet there's nothing so unusual in this. The need to be needed may motivate people to become psychiatrists, and nurses, and social workers, and occupational and physical therapists: all of the so-called helping professions include people who may "need-to-be needed." It is important to recognize this, and learn to develop new approaches to need and dependency, because even those who help or treat may have the tendencies of those who need help.

I remember when I worked on surgical wards, patients would say, "Oh, doctor, I'm so glad I have you; you're so gentle—you never hurt me." I liked those patients. I knew, of course, that I was gentle, and my touch was sure, but it was very nice to hear this confirmed by my patients.

There were others: "Doctor, you didn't come last night when I was in such pain. But that other doctor, he really cares about the patients. He came right away." And these patients, I didn't like. Oh, of course, *I* knew what they said was not true. It was simply that these patients didn't understand how the hospital organized the schedules of its doctors. And I would dismiss from my mind what they had said about me, because it wasn't true, while remembering what the other patients had said about my gentle touch, because it was true.

You know, I was wrong on both counts. Taken at face value the compliment means that I am ignoring the fact that along with the compliment, there is also some anger and hostility in the remark. The patient must feel that he needs my help, and that maybe he shouldn't count completely on my sense of professional responsibility and commitment to him—that perhaps I'm also the kind of person a little flattery won't hurt.

And at the same time, the complaint that I didn't come when the patient needed me may be a paranoid response; but it is more likely there is justification for the complaint—at least a kernel of truth—which I must recognize and acknowledge.

When we are able to do this, we have developed a new approach to need. We are, we hope, nondependent, realistic professionals, with what I call "a healthy, professional cynicism"—interested in, and finding reward in our work; able to assess our own performance level without needing the approval of our patients as proof of our competence; and equally not feeling that we have failed if we hear criticism or anger from our patients.

If we can't achieve this professional realism about ourselves and our work, then we are doomed to repeat over and over again the relationship of mutual dependency which seemed to be developing between Mrs. Stone and her nurse. That is, we are nurses or doctors or social workers or occupational therapists who need to be needed by patients who need us; and we hope that our need—our dependence on our patients—doesn't show. And in our efforts to make sure that our dependence on our patient doesn't become too obvious, we may put too much emphasis on the nondependent aspects of the relationships.

I want to tell you more about what I mean by this last point—about our stressing nondependent components—but there is one more aspect of Mrs. Stone's feelings for her nurse that we should talk about.

The question, What does Mrs. Stone hope to accomplish when she tells you that you are the only one who really understands her? has been the key to our understanding of Mrs. Stone as a person whose feelings of helplessness lead her to a frantic search for someone who will help her, and to her efforts to bind the helper to her.

So we have concentrated on the ulterior purpose of Mrs. Stone's words, but this shouldn't blind us to the fact that her behavior and her words tell us of the real affection and regard she feels for her nurse. She does not tell every staff person, "You are the only one who helps me." Her special feelings are in her words; and you should accept and enjoy her regard for you—even as you must look beyond or behind these good feelings and even as you must refuse to let her use her love to make you feel a sense of personal obligation to her. Your commitment as a professional does not carry with it the obligation to worry about her when you're not on duty. You said last week that you felt like a bad mother abandoning her child. But the child has no right to make the mother feel guilty if she goes away for a weekend holiday with the daddy. Nor does the mother have the right to bind the child so close that the child feels helpless without her.

Yet, this is what people can do to each other if they are unable both to love and also to be nondependent.

Social Worker: I keep thinking about something you said early in the discussion of Mrs. Stone, as an example of a patient whose dependence on staff made for problems—for her and for staff, too. You said that you thought it likely that many of our residents and patients are like Mrs. Stone—not all as excessive or irrational, of course—but dependent all their lives. We have often talked about the fact that very dependent people do seem more likely to think of an institution as a good solution for them in old age—I suppose, because the institution really does take care of them and provide for them. That's the positive side—what they come for; in addition, some things about the institution which some relatively nondependent people find unbearable—the rules and regulations, the large number of people, and the lack of privacy—these things may not be so terrible to the openly dependent person. Or at the least, they may seem to be worth putting up with in return for, or as a part of, the promise of help and care and protection.

And we even have some patients and residents who seem to enjoy the very things about the institution which we often rail against, because we say these things foster dependency and rob the resident of his right to decide things for himself. For example, the requirement that infirmary patients sign out when they leave the floor; or our rules against residents or patients having their own medications; or the rule against infirmary patients going out of the Home without an escort; or the aide checking rooms during the night to make sure everyone is okay.

In any event, I think most of us would agree with you that for very understandable reasons, the resident group includes a high proportion of openly dependent people. And it is undoubtedly true that some of them make an easy adjustment to the Home and are really happy there. But many are like Mrs. Stone—bitterly and tragically miserable themselves, and a serious problem in the institution because of the gloom they spread and their isolation from other residents, and their incessant, time- and energy-consuming demands on staff.

Administrator: I want to underscore this last thing you said. It is my guess that the Mrs. Stones do demand more than their share of staff attention, and that often this means that other, less assertive patients are short-changed. And to compound the problem, staff efforts on their behalf, as in Mrs. Stone's case, seldom still their complaints or make them any happier or more satisfied.

I think, therefore, it would be helpful if Dr. Goldfarb could give us some suggestions about how we should work with patients like Mrs. Stone—what our goals should be. First, I think we have profited from this discussion of Mrs. Stone's

attempt to obligate her nurse to her. The first principle is to develop professional and realistic "cynicism"; and when we feel ourselves wanting to *do*, and *do*, and *do* for a patient, or when patients or their families go out of their way to express particular and special gratitude and admiration to us, we have to ask, Why do I feel that this patient needs so much of my time and effort? and What purpose does this family and patient have in singling me out for special recognition? Now, Dr. Goldfarb, what else can we do?

Dr. Goldfarb: Let's begin by looking at the newly admitted resident—the early weeks and months of her life in the Home. How does this person feel? What kind of help does she need from us and from the institution at this time?

Social Work Supervisor: Let me tell you about a lady we admitted yesterday whose behavior seemed to us to be a perfect example of what we've been talking about—old age as a time of losses and declining ability to manage and a terrible sense of failure. You could watch her and see the whole thing, I think.

Her three children, two daughters and a son, came with her yesterday. She had, of course, been here several times during the application procedure, most recently 2 weeks ago when she came in for her preadmission examination and to look at the room we had for her. Yesterday, though, she had trouble placing herself; she didn't remember where the office of her worker was, although she certainly remembered her worker's face and name. Her face lit up when she saw the worker, and she introduced her to the one daughter who hadn't come with her before.

While they were all sitting in the office, she would reach out to touch and hold the arms or hands of her children—and then make what seemed a visible effort not to cling to them. At least this is how it seemed to me when she'd put her hand on theirs and then pull her hand back and straighten up in her chair and smile at all of us. It's a close family, and the children spoke about their mother—and to her—in ways which showed love and respect and also pride. They talked about their wonderful family life when they were little, about how their friends were always welcome in their house, and about how everyone loved to come there because of both their parents, but mostly their mother.

She had brought some things with her—some medication, and a supplementary doctor's report, and some insurance and bank account information—but when she wanted to give them to the worker, she couldn't find them either in her purse or in a small vanity case she had with her. All of a sudden she just kind of collapsed—I mean that figuratively, not literally.

She is a well-educated lady who was a national officer in one of the big women's organizations, and who managed her household and community responsibilities in a very competent fashion. But when she couldn't find the papers and things, she became very upset and kind of frantically began to go through her purse and case, looking for them in a fluttery, helter-skelter kind of way.

One daughter calmed her down, and her son found the stuff in the case where she had put the things so carefully. But somehow she hadn't seen them until her son showed her that they were there. She was terribly embarrassed and apologetic, and kept saying that she just couldn't understand how she had missed seeing them. She had never done anything so foolish as this in her life, and she did hope we didn't think she was always so incompetent.

I thought to reassure her and said that she shouldn't worry about what had happened; most people were nervous on the day they came to live at the Home, and

I was sure that this accounted for her not finding the papers and things. But she didn't like that. She said that she was not the kind of person who fell apart in a crisis, and besides that, it had been her decision to come into the Home, and she had been looking forward to today, and did not feel in the least nervous.

And just one more thing that seems very sad and also fits in with our discussion of the sense of loss and the decline in self-esteem and confidence that many people feel when they are old and must, as they say, end up in a home for the aged. As we were walking through the lounge, I pointed to a group of residents and said that these were ladies whom I would introduce her to later, because I thought she and they would find they had much in common. They were active in organizations when they were younger; and now in the Home, they run the Golden Age Club and Volunteer Service Program and are generally busy and in leadership roles. I was sure they would welcome her, and that she would soon find herself very involved in organizations here.

She looked at the ladies briefly, but shook her head "No" in response to what I was saying. "They don't know who I was; nobody here will know the person I was."

She really was saying that her life as the person who was *Somebody* was over—that she had lost her sense of identity and purpose and everything when she came here.

Dr. Goldfarb: Can we understand why her sense of loss seems so total?—although as you indicated, she's not different from many others who feel completely lost and helpless at this state. Do we know what had made her and her children decide she should come in? How old is she?

Clinic Nurse: She's 83, but a very well-preserved, attractive 83. Her husband died 13 years ago. She stayed on in their apartment. Her daughter said that her mother and father were very close; they had been married almost 50 years when he died. Mrs. Harris really grieved for her husband, the daughter said, but she worked at making a new life for herself—close to her children and grandchildren, and yet with her own friends and activities and routine. She did fine up until 2 years ago when she fell and fractured her hip. It was slow in mending, but she did make it back to her apartment and was managing fairly well—although her daughter says that the winter months this year were hard for her and she didn't get out very much. She says now, that her mother never really snapped back to her old self after the fracture, and that this year she has really begun to age.

There was no discussion of her coming here or going to live with one of her children until about 6 months ago when her building was sold and the tenants were informed that it was to be torn down this fall. Mrs. Harris says that it just didn't make sense for her to look for a new apartment. "For how long?" she asked. The children would have had to help her, and she knew apartments aren't easy to find, and she didn't want them burdened in this way. "Of course, each of my children offered me a home; but I had my mother-in-law with me for several years when my children were young, and I resolved I'd never do that to my children!"

That's what she said; and then a couple of minutes later, "If I'm going to be a burden, better I burden an institution and people who get paid for it, than to create problems for the children."

Occupational Therapist: I haven't met Mrs. Harris yet. What is it that makes her so sure she's going to need a lot of help and care? At least it seems to me that that's what she's so scared of.

Clinic Nurse: She uses a cane now, and she says that her vision and hearing have gotten worse in the last few years—she'll be checked out next week on this. We don't have all

the results of the tests this morning but so far it's the usual—A.S.H.D. (arteriosclerotic heart disease), diabetes, mild; and the fracture—that's about all.

Social Worker: One other thing: When we first saw her about 4 months ago, the doctor noted "some memory loss; also applicant had some difficulty figuring out how old someone born in 1883 would be today. She covered her lapses well, despite her nervousness. She is a very sociable lady—attractively dressed and polite and outgoing in conversation, and should be able to compensate for the intellectual impairment."

So it seems to me that maybe she hadn't done as well these last few years as she has led her children to believe; and she knew that moving to a new apartment and continuing to live alone was more than she could have handled. Today she had some trouble after she left the clinic, because she didn't understand that an aide was coming to take her back to her room, and she had started back on her own and gotten, as she said, "hopelessly lost." She was trying unsuccessfully to retrace her steps back to the clinic, she said, when one of the aides saw her, and offered to show her the way back to her room. She asked me whether the institution had ever thought of giving new residents guide books and maps, since the Home is so big, and there are so many buildings. She also suggested signs like the ones in the museum which give a floor plan, including an arrow showing where the plan is that you are looking at.

She couldn't understand why we hadn't done this already—"A big, wealthy, philanthropic organization, like this." And meantime, she asked whether I would help her draw a map, showing her room in relation to the clinic, the dining room, and the terrace.

Recreation Worker: You know, she sounds like the patient you were telling us about, Dr. Goldfarb, who complained because you didn't come when he was in pain. You said that because it was a paranoid complaint didn't mean there wasn't a kernel of truth to what he way saying. Here Mrs. Harris sounds angry at this wonderful organization that doesn't know enough, or maybe doesn't care enough, to provide maps for newcomers. It must be easier for her to focus on the institutional failure than for her to admit she couldn't find her own way or even ask someone to help her. But her idea is a good one and I think we ought to follow up on it. That might be just the kind of support that someone like her could use to feel less scared and helpless.

Nurse: I'm not so sure about that. Even a simple map can be hard to figure out if you are scared and feeling totally incompetent, and then if you have a map and get lost anyway, it makes it twice as bad. Hasn't something like that ever happened to you? One time one of my kids accidentally locked herself into our downstairs storage room which has a crazy kind of lock on it. She was screaming and I could not get the lock open. I'm not good mechanically, but I had opened it before. But I panicked, and I know no set of directions could have helped me. I ran for my neighbor and she got it open in a flash. Remember Mrs. Harris not being able to find the stuff in her case when she came in? She sounds like I felt with that lock —just so scared that even though I had opened the lock before, I was just completely helpless. I couldn't do it myself. Someone had to help me.

So with Mrs. Harris; I bet she can do better than she is doing right now if she can just be helped until she gets over her panic. And besides, this place is complicated, and it's easy to get lost. I wouldn't give her maps, as much as I'd assign an aide to take her around until the worst of this panic is over.

Recreation Worker: But I think there are a couple of dangers if we do that. I understand that Mrs. Harris is very frightened now and needs to be given a lot of support and reassurance. But there is the reality of what is possible over the long pull. We can't assign a staff person to her indefinitely, and I'm afraid if we do this now we may be promising her something that we won't be able to maintain—getting her used to a level of service and care that is special, so that when we take it away after a few weeks, she will feel this is another loss and rejection. And in the meantime, Mrs. Harris probably won't have learned her way around because she had not needed to.

The other danger—she got mad yesterday when the social worker tried to reassure her about the papers she couldn't find. She denied that she was nervous and that this might explain her inability to find the papers. And today, from what you said, she didn't ask for help when she got lost. She tried to make it herself and it was the aide who made the offer, not she who asked for help.

Now that I've said this, the two dangers sound incompatible. On the one hand I'm worried about her getting used to too much help, and now I'm saying I don't think she likes people to think she needs any kind of help. But I do think both of these dangers are real.

Dr. Goldfarb: Where are we with our understanding of Mrs. Harris, and what we can do to help her? We talked about Mrs. Stone, who presents interesting contrasts with Mrs. Harris. We understand Mrs. Stone's behavior now as being primarily her frantic, irrational search for the All-Loving, All-Caring Other who will take care of her, because she herself is so helpless. And we asked, How can we help her use what she's got more efficiently? How do we help her gain some feeling of mastery; some relief from her misery? How can we use ourselves and the institution's services to help her?

So we decided to backtrack and look at the individual as she enters the institution, and see if this would help us understand what patients need from us. Mrs. Harris was presented because she is a new resident whose situation prior to her entry into the Home and initial response to the Home seem so dramatically to illustrate some of the things we've been talking about. Let me summarize some of the items in the picture of her which has been presented so far.

We can't say much about causal factors nor do we need to at this point. We do note the fractured hip which left Mrs. Harris with some loss of mobility, and the diabetes which is probably a pretty important factor. When the reports are in we'll have a more complete picture; in the meantime we know from her and her family that over the past 2 years or so there has been a decline in her health and ability to manage.

In addition, it appears that there is some measurable intellectual impairment, and I would suspect that it is this loss which has been most frightening to Mrs. Harris, and which probably weighed most heavily in her decision to enter the Home. Right now it's important that we recognize the possible existence of the brain syndrome, and that we get as accurate an assessment of its severity as quickly as we can. She is the kind of person whom we've talked about before—a very intelligent, sophisticated person, with a fund of information, and a rich repertoire of social skills and graces. I think we'll find that her children were largely unaware of the intellectual impairment, or have seen it, but only very recently, as a minor kind of forgetfulness or momentary lapse. This because she's worked hard at covering her deficits.

She has always been the competent, well-organized do-er and giver, much to her own and her family's pride. When she refused to accept your attempt to excuse her not being able to find those papers, she was, of course, refusing to acknowledge that her accustomed role might now be becoming too difficult for her.

Nurse: I don't understand that, Dr. Goldfarb. It seemed to me that the social worker's words would have reassured her, and sort of excused or explained her lapse: You couldn't find the papers, Mrs. Harris, not because you're slipping intellectually, but because you're nervous. And everyone—not just you, Mrs. Harris—but everyone is nervous the day she comes in. So there's a reason, an excuse for you; and you needn't feel that you must apologize.

That's the way I would have expected Mrs. Harris to understand what the social worker was saying, and it seems to me that this would have made her feel better than what she herself said. She said she couldn't understand why this had happened, but I would think she'd rather know why and know it wasn't so awful—that it was normal.

Dr. Goldfarb: But, you see, Mrs. Harris has never been just "normal"—like anyone else. She has been "her own person"; her feelings of pride and confidence have been contingent on her being able to handle her own problems in her own way. An example of this: her children are proud of her because even though she lost a beloved husband, she didn't fall apart nor did she compensate for the loss by becoming dependent or making demands on them.

Now what the social worker said didn't feel helpful to her; it felt almost like an attack. She is very frustrated about the brain syndrome which is developing—that is, about the lessening in her abilities. And she doesn't want to be confronted with the evidence of her decline, particularly in front of her children. So she thinks it's better to say that this is just an odd, unexplainable, inconsequential, isolated event; otherwise she must acknowledge that it is understandable, and part of a pattern of increasing incompetence and helplessness.

Social Worker: Something else, she didn't want to admit that she was nervous about coming into the Home, because she wants her children to believe that this is really what she wants. If they think she doesn't want to come here, they may insist that she come to one of them; then she won't be able to hide what is happening to her, and she will end up a burden on them. Or worse even, they might not insist; they might feel as she did about her mother-in-law—that the burden was too great—that she'd be better off here.

I'm not sure about this last—I hadn't really thought about it until now.

Occupational Therapist: But isn't there more to it than just her worry about what the children think? That sounds as if Mrs. Harris really understands and accepts the knowledge of what is happening to her, but just doesn't want her children to know how bad off she is. And I guess she *does* understand; because her decision to come into the Home must signify that. I guess I mean she doesn't really *accept* it. She *hates* being old and forgetful, I think; she's ashamed of it, and she doesn't want anyone to know about it—except for staff who are paid for taking care of people like her.

I know what it is! She is sure that no one can love someone who has to be taken care of. That's why it's so total for her: like when the social worker said she and the big shot ladies here have so much in common and they would like her, she said "No," because she's not the person she was—and, therefore, no longer likeable.

But the thing that Mrs. Harris doesn't know is that there are ladies in that group who also have brain syndrome, but who still are sociable and active and attractive, and are not killing themselves trying to deny that they aren't as sharp or as fast as they used to be!

If only we can help Mrs. Harris see that—that life doesn't stop when you come here and that if she can only let down a little—say to herself, All right, I can't do this or that anymore, but I'm still good for some things, and people will still love me, anyway.

Dr. Goldfarb: Yes, Mrs. Harris is, I think, trying to find ways to deal with the losses she is experiencing. Her entry into the Home does seem to signify her understanding of the fact that she can't live as self-sufficiently as she did before. Mrs. Harris has many resources and opportunities for gratification and happiness. True, she is less competent than before. Here in the Home she will find supportive milieu and the medical care she needs. This may help her maintain her usual posture of dealing constructively with problems. She is not being forced to accept loss and decline as the inevitable, and, therefore, untreatable consequences of aging. Rather, some of these losses can be prevented; and more important, excessive disability—that is, impaired functional capacity beyond that warranted by organic impairment—can certainly be prevented.

Physical Therapist: She's scheduled for a complete work-up and evaluation in Physical Medicine and Rehabilitation. I watched her walk when she came to clinic today, and my guess is that we can set up a program that will result in some improvement in her gait. That's one advantage to her being here. Her daughter mentioned to the Clinic Nurse that she was supposed to continue with physical therapy on an outpatient basis, but once she returned to her own apartment, it was hard for her to go regularly to the Rehabilitation Clinic and she stopped altogether about a year ago. Here she can come to clinic easily, and when I talked to her about it this morning, she responded very positively.

Clinic Nurse: She's also scheduled for the routine psychiatric consultation; and I know, Dr. Goldfarb, that the staff doctor left a note for you, asking about an antidepressant. She isn't on anything, but the doctor says that there seem to be no contraindications, and he thinks that she is quite depressed at this point. Mrs. Harris asked for a sleeping pill which the doctor did prescribe; she reported both difficulty in getting to sleep and a very early wakening time. She says this has been for the past 6 months or so; and her daughter said—and she confirmed—that her appetite has not been good lately. The doctor noted these as possible signs of depression, and thought that an antidepressant now might help ease the pain of these first few weeks and also keep her from going into a deeper depression.

Dr. Goldfarb: I haven't seen Mrs. Harris yet, but based on what you've all told us, it is possible that she is somewhat depressed. *Anorexia*, or loss of appetite, and *insomnia* are two cardinal signs of depression. The need for medical care and the use of a hospital or a long-term care facility may tend to depress people, and the depression may contribute to further physical decline.

For a person like Mrs. Harris, even if the decision to enter was hers, the institution does seem particularly assaulting to her sense of what she is. Mrs. Harris was probably already afraid and anxious about the losses in her functional abilities—hence the difficulty in sleeping and eating for at least the past 6 months. Was there any weight loss between the time she was first seen and now?

Nurse: Yes, almost 5 pounds in the 4 months.

Dr. Goldfarb: All right, so we have the beginning of a treatment plan here. We want to give her as complete an examination and evaluation as possible. This may mean a recommendation for a hearing aid or a different prescription for glasses. Improved hearing or vision mean increased or sustained ability to know what's going on around you—of obvious importance in a person's sense of her ability to deal with what is happening. Similarly, it does seem likely that a sustained physical therapy regimen will yield some improvement in Mrs. Harris' gait—help her make more efficient use of what she's got, teach her ways of compensating for the losses already sustained.

We'll want to get a very complete picture of the diabetes and, if necessary, proceed rather carefully in our treatment here—to minimize possible and untoward side-effects in our efforts to stabilize the diabetic condition.

Pharmacologic treatment—we've said that an antidepressant may be indicated in order to reduce Mrs. Harris' present level of anxiety and fear; and again, we'll want to watch her responses to this medication carefully and be prepared to cast about for the proper drug or drugs and amount.

Now one more item in this initial treatment plan, and then I think we've gone about as far as we can today. This has to do with the *amount* and *kind* of support and help and reassurance Mrs. Harris needs from the staff in these early weeks. You remember there was a question about giving her more help now than we will be able to maintain later, and therefore, running the risk that she will feel another loss or rejection when we put her on the routine institutional regime. And also the question about how to offer her help without having her feel that we're saying she needs help because she's not really competent. And third, there was the rather technical question of the form of the help. This came up in our discussion of the map of the institution; the question is, Can she use this kind of a guide, or does she need a personal guide to take her from place to place? or perhaps even a different form of guidance?

First, about the level of help we give now. When you worry about Mrs. Harris' getting too used to help from staff, you're really worrying about the same thing Mrs. Stone's nurse was worrying about, aren't you? You're afraid that she'll get too dependent on staff, and not be able to manage with what you call routine institutional help. Just as our nurse worried that if she walked down the hall with Mrs. Stone, Mrs. Stone wouldn't be able to do it by herself.

But think for a moment about what makes for overdependency in a child.

Chaplain: If a child doesn't receive all the love and attention and guidance he needs, he'll grow old, but not grow up. He'll always be looking for the mothering he didn't get.

This incidentally is the case with Mrs. Stone. Her father came here to the United States without his wife and children and then sent for them after he had accumulated enough money for their passage. Mrs. Stone was the oldest daughter, and she has told me that her mother was sick and that all the responsibility of the younger ones fell to her—and she was twelve or so. She says her life is so awful because she never had anyone who would take care of her. It was always she who had to do for others.

Dr. Goldfarb: An excellent example of what I was getting at. What you have said adds to our understanding of how Mrs. Stone got to be the way she is.

You remember I said that we sometimes try to hide our own need to be needed by concentrating on things which *seem* to prove that we're not encouraging dependence on us.

And in doing this we forget that when people are helpless and need help, they must get that help, even if it is embedded in a dependency relationship. It's only if they aren't assured of help when they need it, that they become scared and begin to try to bind people to them.

Right now, Mrs. Harris needs to experience this as a helping, supporting milieu, and she needs to be offered help in a nonemotional, professional, matter-of-fact kind of way. In fact, the examination and treatment regimen we have been talking about is important in this sense. Treatment implies hope and the possibility of remediation—that is, it does if the doctor-patient and all of the staff-patient relationships offer help and comfort in this matter-of-fact fashion I have been urging.

Moreover, many of you have stressed that this is a complicated place, and everyone needs help—staff as well as newly admitted residents—in finding their way. If we don't give this help now when it's needed most, we're burdening Mrs. Harris with a task she simply can't perform. We're making failure inevitable, and thus making her feel even more helpless and more afraid.

Administrator: It's an interesting paradox, isn't it? We give her help in order that she feel less helpless. If we withhold the help she needs, she will not then feel more able to help herself, as we might hope. But rather she will feel more helpless and more in need.

Nurse: But remember how she felt when the social worker tried to reassure her about the lost papers. I don't think Mrs. Harris is going to be so ready to admit she needs help.

Social Work Supervisor: But she doesn't have to admit she needs help in order to take it—if it's there for her in the matter-of-fact way Dr. Goldfarb is talking about. I think my mistake was in saying anything to her about her not being able to find the papers. She was apologizing and talking about not being able to understand how she had missed seeing them, and that's what I responded to. She is such a gallant lady; I ached for her and the indignity which old age and coming to the Home is causing her.

And now as I think about it, I was really caught up in my pity for her, and that's why I tried to provide excuses for what had happened. I think it would have been much better if I hadn't made such a big thing out of it. It was one thing for her to be apologetic—in a sense her apologies were magnifying the importance of what had happened, and then my words magnified it further. I should have just nodded and said something like, "There's no need to be concerned about it; we have the papers and things we need," and then move on. It was my efforts to reassure her that conveyed to her the message that what had happened was serious; otherwise, why was I trying so hard to explain it?

Dr. Goldfarb: It's very hard to know at the time what the impact of our words will be, but it does appear that a more casual attitude—almost a kind of lack of attention to her lapse—would have been better. I think something like what you have just suggested would have been less likely to make her feel that she was being attacked or perhaps confronted with her failure. One of you said that the great thing would be if Mrs. Harris could believe that she doesn't need to hate and hide her deficits. She probably will be able to do that if her environment doesn't present demands beyond her abilities, because her inability to meet the demands calls attention to her losses. And she'll be more able if the people in her environment also don't call attention to the losses, but simply give her the help she needs.

Occupational Therapist: What you've said already almost answers the questions about the maps, doesn't it? I guess the maps wouldn't hurt so long as the main help is a person; or people, who say: I'm so-and-so and I'm here to do such-and-such or take you to the clinic or the dining room or wherever. Or maybe "take you" isn't good—maybe "go with you" would be better.

The point is, the help she really needs now is to know through experiencing it that it is here, and that it's routine—it doesn't carry with it a special stigma, marking her incompetent.

And at the same time, the guarantee of help should permit her to relax a little and get to know her way around, and when she is able to place the buildings and departments better, she'll feel more self-confident and not afraid of doing as she did this morning—getting *hopelessly* lost.

Dr. Goldfarb: This was what I had in mind—the technical question of form. I do think, as you have indicated, that first she needs most the presence of helping persons around her, and second that—as one of you pointed out earlier—a map might be more than she could handle and thus might lead to another failure.

And now we have, I hope, a clearer picture of the kind of help the aged person needs from the institution and its staff. We went from Mrs. Stone to a new resident to get at some of these things, but I think you can see that it really makes no difference whether the person is new to the institution as Mrs. Harris is, or an old-timer like Mrs. Stone. It's just that it's sometimes hard to cast a fresh look at our work with the old-timers—easier to see what is needed at the beginning, not in process.

In our next session we can pick up anything that isn't clear or satisfactory from our discussions of Mrs. Harris and Mrs. Stone and then perhaps move to another of the original questions you posed for this discussion of the emotional disorders and management problems of the aged residents and patients in our institutions.

Session V

Mrs. Harris (Continued)

Dr. Goldfarb: How is Mrs. Harris doing this week? Has she been able to adjust to the routine of the Home? This is her second week here—does she show signs of accepting what the Home offers for making her life more comfortable and satisfying?

Social Work Supervisor: It's been 10 days since she came in. It's not been as bad for her as we had feared it was going to be.

I think we've done better with her because of our discussion than we might have done otherwise. We had tended to identify with her. I kept thinking how terrible it is for a person like Mrs. Harris—such an unusual person, as wife and mother and in the community—to be in an institution, to be cared for rather than being able to care for others, and to continue as an independent person, as a giver and doer for others. I had tended to focus on things in the Home that Mrs. Harris would find painful, and forgot what we have to offer her that's good; she'll really be better off here than alone and frightened in her apartment.

Physical Therapist: That's the important point. She has had an appointment with me every day since she's been here. We can help her walk. Of course, it'll be some weeks before the difference will be obvious.

When I talked with her the first day, her response to me and the treatment program was positive. However, on actually beginning, she was hesitant and pessimistic about the program. But physical therapy had been prescribed (was not optional); and the aide, the nurse, and her social worker, and I all handled it firmly and matter-of-factly. So Mrs. Harris said she'd give it a try, and so far, she is working well.

Another thing: she seems to benefit emotionally from the physical therapy sessions. She says it's better than sitting around and doing nothing and the thought that she is working on her physical problems, the regular schedule, and the milieu give her some purpose and direction. It seems good that her appointment is early in the morning. At that time, like most of our patients, she's stronger and more energetic. The treatment also gets her moving—gives her a reason to get out of bed and get dressed and to start the day.

Chaplain: A lady like Mrs. Harris probably wants to keep active and involved because this has been her lifelong pattern. Should we be urging and even pushing a little to get her into our programs and activities?

Recreation Worker: She attended the New Residents' Group Meeting this week, but she refused an invitation to play bridge with the Tuesday Night Ladies' Card Club.

Social Work Supervisor: Her social worker has already talked to her about various activities, but she said she'd rather wait until she's better settled. Also we'd like to complete her medical workup.

She refused her daughter's invitation to stay with her over the weekend. She gave her new medication as the excuse, but also said she'd better not start running around until she's settled here.

Since our discussion of Mrs. Harris, we've tried to assure her of the presence of helpers, in such a way that it doesn't make her feel she's incompetent. An aide sees her first thing in the morning, walks with her to meals and to medical appointments. During the day she visits briefly with her at frequent intervals to see if help is needed.

If so, she says something like, "Let me help you to such and such," and begins to help as she says the words. We think this is better than a general, "Is there anything you want me to do?" because Mrs. Harris answers such a question with, "*No*, there's nothing." As we are approaching her now, she permits the aide to help her in this matter-of-fact way.

In the morning the aide discusses the day's schedule and gives Mrs. Harris a written copy of it. As I mentioned, the aide walks Mrs. Harris to each appointment. Without needing to say any words like, "Don't forget, you're due at the beauty parlor at 3:00," the aide, by her presence, is a memory jog for Mrs. Harris. In view of her angry response to my verbalization of support last week, we're trying to *give* service and help, with little discussion about it, and in a businesslike, unemotional way. We don't call Mrs. Harris's attention to her failures but simply supply her with information and assistance to help her keep her appointments.

Social Worker: Something happened that supports what we have been talking about. When we assigned the aide to Mrs. Harris last week, I just brought the aide to meet her, and told Mrs. Harris that the aide, like me, was assigned to help her.

The first day, the aide stayed close to her. Early in the afternoon, Mrs. Harris realized that she was the aide's only assignment, and she didn't like it. She reacted somewhat as she had with the papers she couldn't find. She told the aide that there was no need for her to stay with her all the time, and, moreover, that she liked her privacy and didn't want someone "hovering over her." She asked that the aide tell me that she appreciates our efforts, but she does not need a "keeper."

At that point, we revised the aide's assignment. The aide is there for appointments and at particular times of the day—when Mrs. Harris is getting dressed, for example. It seems to be working out well.

Administrator: Dr. Goldfarb, you once talked about a *"catastrophic reaction."*

Dr. Goldfarb: This phrase was coined by Kurt Goldstein, to describe the reaction of persons with impaired intellectual capacities to environmental demands which are in excess of their capacities. Anxiety under these circumstances has a disorganizing effect upon their thinking and affects their behavior adversely. They function suboptimally and may become unable to meet any of the demands made on them, even those which in the absence of anxiety, they dealt with easily. They are overwhelmed and immobilized. Do you believe that Mrs. Harris suffers *"catastrophic reaction"*?

Administrator: Living alone in her apartment this last year might have exposed her repeatedly to excessive demands. If so, she may have been unable at times to feed or care for herself properly. Fear may have caused her to remain in her apartment—yes, she may have suffered some "catastrophic reaction."

If so, perhaps her first days here have been better than we expected, because by decreasing her fear, we helped her to become optimally organized to use well the assets that remain. Of course the Home is new to her, and therefore frightening. But, unlike her apartment, the Home environment is tailored to the needs

and capabilities of the aged. It is a protective, supportive *care-oriented environment*. People come here because they need its protection and the care provided.

Mrs. Harris seems to need an environment which imposes no demands on her that she can't meet, an environment in which she is unlikely to be faced by her failures. On a physical level—here there are no stairs for her to climb in contrast to her apartment which was reached by a number of steps from sidewalk to front door. That was one reason she didn't get out much last winter.

Our routine, the help with her schedule, our reminder announcements over the public address system, our bulletin board—all these decrease her need to remember and to keep track of dates, appointments, meals, or meetings.

In addition, we watch her weight. She had lost weight in the 4 months before joining us here. She has already gained almost a pound. She herself states that it's probably because she's now eating three meals a day. At home, alone, she often skipped meals.

You know, over and over again when we ask applicants or new residents about their eating habits and diets, we find that the ones who have been living alone in apartments almost always say this—that it was just too much trouble to cook for one person. And so their meals were irregular and often no more than bread and cheese or dry cereal—things that don't require preparation.

Dr. Goldfarb: Some people call this "the tea and toast syndrome!"

Nurse: I don't think I ever really thought about what those words meant; for many older persons, "too much trouble" really may have meant "too difficult"—one of the things that they couldn't manage because they didn't have enough strength or motor coordination or even the memory of how to cook.

That Mrs. Harris now eats three meals a day—without having to remember that it's time to eat and without having to shop and plan and cook and clean up—is a very important part of care. Not only is the effect physical because she's eating regular and nutritious meals, but also it's psychological—she doesn't have to worry about meals or use up any strength to shop, cook, or clean up.

Dr. Goldfarb: Not only do old people fail to cook for themselves because their physical and mental strength does not suffice but also because they are depressed and have no appetite. Our Mrs. Harris in her apartment wasn't yet immobilized or completely overwhelmed. She was well enough to make her own decision to come here. But certainly things were getting too much for her. She seemed to be on a downward spiral for the last 6 to 12 months. At present the institution serves her as a therapeutic, prosthetic milieu. It doesn't demand more than she can do. It supports, props up, strengthens the capabilities she still has. For this I use the word prosthetic because what the institution as an entity does can be likened to what hearing aids or eyeglasses or canes do separately. They add or supplement or compensate for losses or deficits. They make continued functioning possible. They turn failure to success and add to comfort and confidence.

The 'prosthetic environment,' physical therapy, regular diet, announcements to jog the memory help persons with cerebral damage to use what's left in a more efficient fashion than they could otherwise—in their own homes or in the homes of children. Your assumption that Mrs. Harris will continue to improve may be correct. The impairments she has sustained cannot be reversed, but excess disability can be reduced and avoided in this supportive, protective milieu. Behavior can be improved in many ways; mood can be improved and content of thought may be beneficially altered.

Chaplain: About living with her children: Mrs. Harris is a fine, cultured, intelligent, always attractively dressed, and well-spoken woman. What trouble would she be to her children? Why wouldn't living with a child work out well?

I know she says it was her decision to come here, but her children could have insisted that she come with them. I can't see that she is better off here than in the home of one of her daughters. Couldn't she get the help you're talking about there equally well? Her children are not poor, they live in nice homes. It's not like it is with some of our other residents whose children are struggling to make a living, where the couple both work and have small apartments, with no room for the mother. You have been talking about the good things for Mrs. Harris here at the Home. But don't forget the bad things. She has talked to me this week also. The dining room—she has lived alone all these years and now she must eat all her meals surrounded by 250 other people, the manners of many of whom are offensive to her. Many, we all know, are untidy in their eating because of their shaking hands and poor eyesight. It bothers Mrs. Harris, although she tries not to show it. And her roommate: she has lived in privacy for so long, and by a schedule of her own. Now, at age 83, she lives intimately in a small room with a stranger. Why say more? What I ask is this: Wouldn't it have been much better for her if she could have lived at her daughter's? Arrangements could have been made for the physical therapy and the other treatments at home or as an outpatient without the pain and indignity of living with strangers in her old age.

Dr. Goldfarb: You are right to remind us that there is much that is difficult for Mrs. Harris in coming here to live. Some of the things you have mentioned are not just painful and hard during this initial period of adjustment. Mrs. Harris may never really enjoy the large dining room, although we hope she will become somewhat accustomed to it. Similarly, a roommate may very well continue to be a problem for her; and she may go on wishing for more privacy and to be treated more as an individual, rather than as one of many.

But I think we differ in our estimate of the kind of care that could be provided for Mrs. Harris in her daughter's home, and in the judgment of the wisdom of such an arrangement.

Mrs. Harris can't function as well as she has here this week, except with the kind of support and care she has received here. She needs help in getting organized and "on her way" in the morning. She needs to be reminded when to eat and what time she's to do the routine everyday things. She seems to need—now, or will soon—assistance with keeping track of her clothing and possessions and in laundering, personal hygiene, and even with the mechanics of getting dressed.

She needs a regular, daily physical therapy session; she is on several essential medicines, which we cannot trust to her memory to take correctly. Someone must be sure she takes her medicine in the prescribed amount at the prescribed time, and must watch with a trained eye her reaction to the medicines.

To do this, Mrs. Harris' daughter would end up running a *"one-bed nursing home"* in her home. This is not a manageable enterprise except at a terrible cost—not simply financial—to the family. Moreover, the care Mrs. Harris would receive in her one-bed facility simply can't be as good as the care provided in an institution like this where the size of the institution alone makes possible a wide range and continuity of services and programs.

The real tragedy old people and their families face today is not the pain Mrs. Harris is experiencing in her entry into this institutional system. She and her family are among the lucky ones. The real tragedies are experienced by those who are not

lucky enough to get into a Home like this. Those families then have a difficult choice. They can try to make their home a one-bed nursing home at the expense of their own and their childrens' needs and with the knowledge that they can't really provide the care the old one needs. Or they can settle for the relatively inadequate nursing home beds that are available to them in the community.

This is a critical point. You are on the staff of a first-rate institution for the aged, and we know that the Mrs. Harrises are here because they need to be. We know that the level of care they need is beyond the resources of the family and that it is here that they will be well taken care of. Yet we forget what we know sometimes—or maybe it's that our beliefs and ideas from earlier times prevail over those more recently acquired.

Nurse: I, too, think most of our old people would rather be with their children than here in the institution; and I think, also, the children usually feel guilty—as if they must explain and justify putting their mother here.

Obviously we have mixed feelings. We know this is a good institution and that our residents and patients are well taken care of. Yet we can't help but sympathize with their wish not to be here. And we can understand their feeling that their children have an obligation to them which they have not lived up to.

Dr. Goldfarb: What is the nature of the obligation? Is it to see that the parent gets the best possible care?

Nurse: The old person may not see this institution, or any place like it, as the best of all possible care—"The best is in the community, with my family." Maybe it's more important that they be where they want to be—where they think they should be—even if the care there isn't as good or as comprehensive as it is here.

Administrator: In my opinion you're making the same mistake—only in an opposite direction—that the Chaplain accused us of making. He said we were looking only at the good things about the institution and not at its defects. And I think in these last few comments, you have been looking at home care for the aged through very rose-colored glasses, and what you see through these glasses is pretty far from reality.

As an example: How many frantic phone calls do we get from long-suffering relatives, now at the end of their ropes? The mother moved in with the daughter, as some of you feel Mrs. Harris should have done, and maybe daughter stayed home with mama, who can't be left alone all day, partly because she has occasional lapses of memory like turning on the gas and forgetting to light it, partly because she becomes very hurt when daughter seems to want to be away from mama more than with her.

But daughter has other responsibilities—her husband, her children. Perhaps she works; and she's human too and wants some time to herself and with her friends. Pretty soon mama is feeling very hurt and angry, because her daughter isn't willing to care for mama as mama did for her when she was little and dependent. And daughter is feeling guilty about mama, but also angry at mama for making unreasonable demands and not understanding why she can't be at her beck and call the way mama was for her.

And that's when we get the frantic phone call—from the daughter usually. But sometimes it's the daughter's husband who calls his friend, the Board member—"You gotta take her in; either she leaves or I do." In any event the mama is no less miserable in her daughter's home than is Mrs. Harris here. She isn't as well

cared for; and her children are on the verge of divorce or nervous collapse, and more, her grandchildren also suffer.

Chaplain: But wait. I didn't suggest that the children, themselves, should be with the mother 24 hours a day, 7 days a week. No; of course, this is beyond the demands of filial respect and devotion. I said, in fact, that I thought Mrs. Harris could live out her days at her daughter's precisely because there is money enough to pay for the companion or aide Mrs. Harris may need.

Social Work Supervisor: But Chaplain, the frantic phone call, "You've got to take my mother in," often comes from the family who has done what you're suggesting. They've hired companions and aides and even RN's, but they can't get anyone that mama will accept or who will stay with mama. For example, mama insists that the aide doesn't do anything—she just sits there and watches TV. Sometimes mama refuses to let the aide or anyone in her kitchen, and mama ends up cooking or trying to cook for two—or at least so she reports.

Nurse: I specialed a lady like that one time. I hate to admit this but she drove me up the wall. Either she would talk and talk and talk, or when she was quiet I might turn the TV on or try to read. And she wouldn't like the program I had chosen, or she wanted me to read to her—but not from what I was reading. Well, 8 hours alone in a studio apartment with this lady got to be impossible. After a week I told the daughter I just couldn't stay on the job and asked her to please get someone else fast.

Dr. Goldfarb: The problems which several of you have described—the daughter who can't be a full-time companion, and the nurse who can't continue on the job—are very real and quite common. I want to emphasize again my earlier point, particularly in response to the Chaplain's words. Most families simply do not have the resources —space, money, family members free to stay home—that are required in order to maintain the impaired and infirm old person at home.

And even when the family is an affluent one and has the resources necessary to provide for home care for mama, this alternative which seems so ideal breaks down also. As you point out, the companion or aide or RN quits or is fired, and this happens over and over again until finally the frantic call comes to our Social Services Department.

Understand, I am not arguing for institutional care for all aged. I am, however, arguing for it for many of the impaired and infirm. I am saying that here they receive the care and treatment they require that cannot be provided at a satisfactory level at home. Further, I would argue that it is we in this room, and our society as a whole who have failed—but we actually do not feel guilty. We try to show the children that the "guilt" they feel is actually anger—their anger at us and at society because we do not give them the help they need. The children who bring mother here have not failed and are not guilty. The real failure is our failure as a society in not providing enough long-term care facilities for the sick aged or enough good residential facilities for the physically well-brain-damaged.

Our failure is one of attitude also; so long as we have these doubts about the appropriateness and therapeutic value of institutions like this, so long as we pity the Mrs. Harrises and blame their children, we perpetuate the failure of our society.

Well, end of lecture for today. Let's stop now with a brief summary of our discussion of Mrs. Harris and the Home. We see Mrs. Harris as a person with some physical health problems, but still in reasonably good health and physically functioning well. If there aren't too many steps or long distances she walks well enough, albeit

with a cane. She sees and hears well enough with the aid of glasses and a hearing aid so that she is able to maintain communication with other people and is interested in things and events in her environment. She needs an environment tailored to her infirmities—as this environment is—and in addition, she needs a milieu in which account is automatically taken of her impaired intellectual capacities. This means nursing supervision and personal assistance. It means some medical and paramedical treatment. It means the kind of additional supports and protections which are built into a setting such as this—staff members helping; memory jogs; not too much complexity and activity; the structured regularity of the schedule, and daily routine of the institution.

We are optimistic about her ability to adapt to the Home and even to be reasonably happy here. It does seem that during the past year Mrs. Harris had been confronted with environmental demands which she couldn't meet, and that her response to these excessive demands was very near to panic, followed by still further decline in her ability to mobilize her remaining resources in an effort to deal with her daily routine.

Now that she is no longer being overwhelmed by demands she can't meet, her feelings of panic will probably subside. When faced by more realistic demands, she will be able to concentrate her efforts and use her remaining resources more efficiently and successfully.

And a cliché to end the session: There's nothing that succeeds like success! By this I mean that as she succeeds in meeting the lower level of demands being made on her in this environment, success should bolster her picture of herself so that she will be able to risk more complex, more demanding situations—like the Tuesday Bridge game, or a weekend at her daughter's.

Session VI

The Personality of the Brain Syndrome Patient

Recreation Worker: During our last several sessions, we have been talking about three patients—Mrs. Stone, Mrs. Harris, and briefly, Mrs. Fisch. The diagnosis for Mrs. Stone is brain syndrome moderate and for Mrs. Harris, brain syndrome mild.

Now the question I have is about their personalities: Are they the same as when they were younger? Has age and impairment changed the kind of people they are?

Dr. Goldfarb: Do you think people are likely to remain the same as they age and perhaps develop brain syndrome, or that one's behavior changes in an age-connected way; and may be further altered by the development of brain syndrome?

Physical Therapist: I see that patients get frustrated and disturbed by their inability to manage as well or do as much as they used to—like Mrs. Harris. Frequently they go from this frustration to anger at themselves and to general irritability which is directed at everyone around them.

They can't tolerate delay or disappointment, and seem to lose ability to maintain control of themselves.

Women lose their tempers in unladylike fashion and yell or curse at other residents who get in their way. I've always assumed that the loss of brain cells included losses in the areas of the brain where mechanisms of control are located. Is this accurate?

Occupational Therapist: You can't generalize about personality or behavior. Our patients are very different from each other in old age. Some, like Mrs. Fisch and, I guess, Mrs. Harris, are able to cope successfully with the developmental tasks and the problems and losses of old age. Others just can't accept that they are growing old and they never are able to work out a new equilibrium for themselves—Mrs. Stone, for instance. I think how they do now will depend almost entirely on their previous lifestyles and coping mechanisms.

Dr. Goldfarb: Isn't there an inconsistency in what you are saying? You say that it's impossible to generalize. Yet, you end with a generalization. You say the ability of the aged individual to meet the demands of this period in his life will depend largely on his previously developed coping mechanisms and lifestyle. Let me ask you: Can we predict how the person will react to the aging process, based on his earlier style and the means he customarily used to adapt to and with life's problems and challenges?

Occupational Therapist: We can get a pretty accurate picture of how a person is going to do here at the Home if we know what kind of a young adult or middle-aged person he was.

When I said you can't generalize, I meant that you can't say that there are certain personality types or modes of adjustment that are typical for this age group. Each old person is unique, and they don't all become alike just because they're old.

We can assume there is a connection or there is a similarity between the kind of old person one has become and the kind of younger person one was.

Social Work Supervisor: I don't agree entirely. Of course, what we were yesterday affects what we are today and will be tomorrow. But here we have aging and brain syndrome to consider: it doesn't seem possible to me that such crucial factors do not affect the emotions, the personality of the individual. For example, we've already mentioned that frustration and irritability are seen in brain damaged patients. Does this occur in persons who had been described as even-tempered and serene people by those who knew them before?

Sometimes I think of personality as being like an onion with its layers. What happens is that layer after layer of social inhibitions and control drop off, and what is left is an impulsive, demanding, egocentric old person. Such a person seems different from before the losses of these layers of ability to control her behavior—and this, regardless of what her lifestyle had been 10 or 20 years and a lot of brain cells and personality layers ago.

Dr. Goldfarb: If we look at it in the way you are suggesting, we would be saying that as intellectual deficits occur, certain personality traits or resources are lost, and as they are peeled away, other traits previously hidden or contained, are then revealed.

This may be a useful concept; however, I look at this matter of personality and behavior somewhat differently. I begin with a question: What do we mean by personality? If we talk about personality change, what aspects of a person's method of dealing with his environment are we talking about? If we talk of a middle-aged, aggressive, dominating, successful business tycoon, is his personality the same when he is alone with his wife as it is when he is giving his staff orders for the day? Is he the same when negotiating with the president of the union that has organized his factories as he is when he goes for a Father-Daughter weekend at his daughter's college? Personality consists of a multiplicity of adaptive devices. Mr. Tycoon may look like a different person in each of these situations. At times he's impatient, impersonal, demanding as a general marshaling his troops. At the bargaining table he is a negotiator, moving slowly—seeking out his opponent's strengths and weaknesses; speaking softly—anxious to find a settlement which both he and the union leader can live with. With his wife he may sometimes seem bored, impatient and critical. Or perhaps he may brag about what a smooth negotiator he is or may talk about feelings toward his staff which are otherwise carefully masked behind his impersonal and demanding approach. With his daughter, at her college, he may relax in a different way. He may shed his years and his dignity for a moment. He goes bowling or he joins an informal barbershop quartet in songs from his own college days. He may tell his specially beloved daughter of some of the events of his youth or even of the dreams he dreamed when he was her age.

Which is Mr. Tycoon's basic, enduring personality or style? Which Mr. Tycoon will we see 20 years from now when his daughter brings him to us?

Administrator: Perhaps we must not assume that there is a basic personality on which psychological changes or events in the real world impinge and thereby change.

Dr. Goldfarb: Widely different types of behavior may arise in persons of basically similar personality.

Nurse: But where does that leave us? You say we can't talk about a personality in a vacuum, but must talk about the person in a given situation and that how he behaves will depend largely on how he perceives the situation and what meaning it has for him. Isn't that true of people at any age? Does that help us to understand the effects of brain syndrome on the behavior of the individual?

Dr. Goldfarb: Can we find any direct connection between brain damage and emotions and behavior? What are the signs of brain damage?

Nurse: Intellectual deficit is one.

Dr. Goldfarb: Yes. What about affect? Do you think changes in mood of aged persons may occur as a consequence of brain damage? Irritability has been mentioned as common in our patients in the Home. Irritability, a mild expression of rage related to the inability to tolerate frustrations, seems characteristic of many old people. But probably the most widely experienced affective disorder among the aged is that of depression.

Can we say that irritability or depression or other changes in affect are directly caused by brain damage? Is there a direct connection between brain damage and the moods or the affect of the individual?

Chaplain: We have a patient here who some years ago had an operation on her brain in order to make her less depressed. If an operation can make a person less depressed, then can brain change, like damage due to illness or an accident, cause change in mood?

Dr. Goldfarb: The patient probably had a prefrontal lobotomy, an operation advocated by some psychiatrists for intractable depression, as a last resort after all other treatment has failed.

I continue to believe however that the damage to the brain which occurs with aging is not usually the most important cause of change in mood.

Having said this, I am left with the task of accounting for the high incidence of depression among the aged, or of explaining why the irritability you spoke of does seem to be more common in aged brain syndrome patients than in younger persons. Why do old people who were reasonably happy before become depressed? Why is it that "a perfect lady" of the past, when she develops brain syndrome becomes a cursing, yelling fish-wife?

Much of the personality change which is thought to be a consequence of aging and brain damage may actually be a reflection of the individual's response to aging and his loss, also of his attempts to deal with its effects upon him.

Nurse: But what difference does it make in our work if these ways of getting along are the result of brain damage or occur in reaction to damage? Regardless of which it is, there are psychiatric disorders that are more common among the old and impaired than in other groups. For many of the old the disorder is new, they didn't have it until they were old—or at least not in its present severity. Does any kind of difference in treatment and care follow from the distinction that you have made?

Administrator: I think I see why the distinction is important. If the irritability and inability to tolerate frustration are caused by brain damage then, like the intellectual losses of the brain syndrome patient, the mood or personality changes would be irremediable or irreversible. If the lady who curses and hits does so because an area of her brain has been destroyed then there is nothing we can do, I guess, except give her sedatives and restrain her to make her behavior less troublesome.

But Dr. Goldfarb is saying that her cranky, irritated, demanding behavior may be her response to losses she is experiencing. She could be saying, "If you gave me the help I need, I wouldn't be in this fix. I can't walk well anymore and the therapist doesn't give me enough or even proper treatment."

Maybe she's past that point. She knows she's getting worse, and knows it can't be blamed on anyone. There are times when she asks, "Why me?" At such a time, feeling angry, she may strike out against the envied, luckier around her. Another possibility: Demanding, often irritable behavior may be part of complicated efforts to secure the alliance of a strong, protective, all-giving helper, as we previously discussed.

Once we view the behavior of the person as a response to old age and declining functional capacities, we can see that there are things we can do to help, that we can help the person help himself and that it is not unreasonable to expect some payoff for our efforts. Behavior can be changed even if the memory can't be improved.

Social Work Supervisor: I agree. For example, Mr. Green's intellect is so severely impaired that he is not testable by the "Special Ten" (Mental Status Questionnaire). We tend to forget the severity of his brain syndrome because on his unit where everyone knows and likes him and automatically helps him, he does very well. However, on the rare occasions when he is taken off the unit—for instance to the clinic or physical therapy, he is anxious and restless. If he has to wait in the clinic for any length of time, or if there are many questions, or if he's asked to do several things—like walk from desk to chair so doctor can observe his gait or move his hand according to instructions from the physical therapist—then Mr. Green becomes very upset.

The sweet, agreeable man we know on his own unit disappears, and in his place is a new Mr. Green who is uncooperative and ready to use his cane on the doctor or therapist who "keep bothering him with silly questions."

Because this man spends most of his time in the uncomplicated, quiet, undemanding milieu of his unit, we see the disturbed Mr. Green only rarely. But many severely impaired old people like him are living in environments in which there are too many stimuli for them to deal with comfortably; too many demands are made on them; they receive too little help. They blow up, the way Mr. Green does, when things get too much for him.

When an old person blows up in his own home, his family may assume he's behaving this way because of his brain damage, and that nothing can be done except to restrain or isolate him.

It would help if they saw this change in behavior as an understandable response to a situation which is too much for him and if they knew enough to change the environment to make it less demanding, challenging, and threatening. With help, he would not become stubborn, uncooperative—blow up or strike out at the people he sees as demanding too much from him.

Dr. Goldfarb: In summary, we started with the question of whether the aged brain syndrome patient is pretty much like he's always been or whether he behaves differently today as a result of the impact of the brain damage on his personality.

I began by asking you to look at this notion of a basic personality or pattern of behavior; and I have argued that at any age, a person possesses a repertoire of roles and ways of behaving from which he selects the most appropriate one based on his understanding of the situation and its meaning to him.

Of course, each of us can be described in general terms. I have, for example, said that it is possible to classify people along a continuum from overly dependent to nondependent, and that individuals who grow up socialized so as to be nondependent or dependent will probably remain so throughout their lifetime.

But even then, there is a range of roles our nondependent Mr. Tycoon, for example, plays in a day and during his lifetime, because there are countless different ways Mr. Tycoon uses to assert his dominant personality. Similarly, there are many quite different ways a Mrs. Overly Dependent might try in her effort to secure the one on whom she can depend. Because of this variety and range for each individual, we may think we are seeing a person completely changed in old age from his younger self when, in reality, the change we note is simply the same person's adapting his behavior to a new and different situation with actuai resources.

Mr. Tycoon, for example, might see the Home as a place where ingratiating and cooperative and nondemanding behavior will gain for him a position of special privilege and of power. This would be in sharp contrast to the Mr. Tycoon his employees and business associates knew. They would say that something has happened to Mr. Tycoon in the institution; he's a completely different person. But, of course, he isn't. He still wants to dominate and control; but here he thinks he'll do better as "Mr. Nice Guy" than if he tried to be "the Boss." When you ask whether the behavior personality of the aged brain syndrome patient entering this institution will be the same as it was when he was younger and nondamaged, I will answer with five interrelated statements. *First,* we can talk about different types of people with respect to certain very key aspects of personality—for example, the quality of dependency or nondependency—and in these terms, shifts from one type to another probably occur only rarely over the lifetime of the adult. *Second,* a wide range of personalities, roles, kinds of behavior exist for each type, and the choice from the range will depend on the individual's understanding of the situation and his goals in relation to it. *Third,* the range is so wide that we may see the individual as completely different, when in fact all that has happened has been a change in the details of behavior as he adapts himself to a new situation. *Fourth,* in my judgment much of the behavior which we commonly associated with the aging process and assumed to be caused by organic factors is, in fact, the manifestation of the individual's responses and attempts to deal with what is happening to him. And *fifth,* it is this view (which should tell you what you do for the aged and impaired *does* make a difference to them) that can lead to changes for the better in their sense of well-being and in their behavior. Nevertheless there are probably specific alterations of behavior which occur when specific areas of the brain are damaged. These can be manifested in the absence of what we call brain syndrome. For example, there may be special symptoms occurring when there is temporal lobe damage.

Physical Therapist: But, there are limits to the kind or extent of behavioral improvement we can expect, aren't there? Isn't it true that with a person who is severely impaired, no matter how hard we try or how good we are, we can't repair the parts of the brain that have been damaged?

Dr. Goldfarb: Yes, that's true. With severely impaired chronic brain syndrome patients, patient care must include realistic assessment of the remaining capabilities and resources so that the patient is not overwhelmed by our treatment plans for him. We need to know what assets remain. This is one reason why it is so important that our

testing procedures tell us more than whether brain syndrome is present or absent. We need to know the degree of impairment. The patient who fails the "Face-Hand" test with eyes closed, but answers correctly with eyes open is doing better than one who fails with eyes open as well as with eyes closed.

If we are accurate in our assessments as to degree of impairment, if we can specify the areas of impairment, we are less likely to push patients with brain syndrome to emotional over-reaction. We will avoid pressing him toward physical assault on people who won't let him alone but don't help him. Also we will not dismiss as organic—and therefore, irremedial—the disturbed and seemingly confused behavior of an old person which is in fact symptomatic of depression for which the prognosis is good, if he is given proper care and treatment.

Before closing I think it should be understood that with aging of the brain, learning capacity may remain just as good but may take longer—that multiple stimuli may lead to perceptual failure and decrease pleasure. An old person may enjoy music more with eyes closed and no one on stage before him than when sight and sound are simultaneously stimulated; conversely, he may enjoy a play more than a noisy musical and may understand and enjoy and be stimulated by the relatively slow moving discussion far more than by rapid fire resonances and multi-media approaches.

Session VII

Individual Behavior and Special Problems

Dr. Goldfarb: Patient behavior often creates special problems for the individual in the closed society of the institution. You have suggested two examples of such behavior: Mr. White's attack on Mr. Block during a Men's Club meeting, and the sexual advance made by a male patient to a female patient during an Occupational Therapy session.

In the Men's Club situation one man tried to hit another one. The battle was brief; no one was hurt. How do you regard this event?

Social Worker: As the worker with the Men's Club I see fights or, as in this case, one resident's attack on another as a problem. I don't understand why so many of our residents and patients have so little control over their tempers, why they seem to feel that they have the right to yell and curse at other residents, and even try to do physical harm to another.

Maybe some of our residents feel that they don't *have* to control themselves or to make any kinds of adjustments to the total resident community. I understood you to say that usually this kind of behavior cannot be attributed to damage to specific areas of the brain. If it's not a matter of brain damage, why do people here behave in this way? Mr. Block had done nothing to Mr. White. In fact he was trying to help Mr. White with his coffee.

Also I don't know what to say to the men when they say we shouldn't admit people like Mr. White. Or if they concede that even the Mr. Whites need a home, they feel these people should be isolated from the rest of the community. And they seem to want Mr. White to be publicly reprimanded.

Dr. Goldfarb: When people believe that if an individual behaves in a certain way he should be punished publicly and/or confined to a special place, one thing they are saying is that the person's behavior is intolerable to them in their society.

There are probably some things which are found intolerable in most societies. But there are probably many kinds of behavior about which there is not this cross-culture unanimity of opinion.

This is a *Jewish philanthropic institution* for old people. Probably because of its social characteristics there are things which would be perfectly acceptable—or at least tolerable—outside the institution, but which people may believe should not be allowed here.

Even among homes for the aged, you can find very interesting differences, depending primarily on the sociocultural background of its sponsors and residents. Here your men play cards for money, and alcoholic beverages are not contraband. At the Catholic Home nearby, the afternoon cocktail hour is a daily routine. But both card games for money and drinking are often explicitly forbidden in many homes under other auspices.

Much depends on a community's attitude toward the behavior of the individual. There are situations where it is taken for granted that old men will disagree,

and that sometimes they will brandish their canes at each other, and even land a few blows before the fight is over. But this kind of behavior is apparently not easily tolerated here in this institution.

Do you know neighborhoods where a man takes a poke at his next door neighbor? Maybe the argument was about the damage a dog did to a garden or the war in Vietnam or about who was the greatest right-hand pitcher in the history of baseball.

Or has it ever happened to you that another driver cuts in front of you and you almost hit a truck in swerving to avoid him. And suddenly you're in a murderous rage, and possibly thinking, if not shouting, obscenities to him as he drives off without a backward glance?

These are pretty commonplace kinds of situations. Most of us lose our tempers from time to time. We may yell or curse or throw something, if not slap or hit. If this is not unusual behavior, why is it a special problem in this Home? Is it merely because there's less privacy here than in a family setting? If there hadn't been an audience, would the fight still have constituted a problem?

Nurse: I'm not sure that the audience at the time and the gossip later are the only reasons why a fight between residents is a problem in the Home. I think even if it happens in their room, and no one knows about it except the two of them, the fight would be a problem. Certainly, if staff hears about it, we couldn't just ignore it, as you might if you happened to witness a fight between two of your neighbors.

For one thing harm can be done. They might not have enough strength to land a solid blow, but even light blows may harm old people.

Social Worker: There's something else that makes it different from a fight between neighbors. People are here because they need a protective environment. We can't just say it's natural for people to fight and that if we don't make a Federal case out of it, there won't be any problem.

The families of our residents, the board, the community, other residents would have a right to say that if the Men's Club worker hadn't separated the two men, he was derelict in his duties. He had not provided the protection these two men and the rest of the club members have a right to expect here at the Home.

Physical Therapist: Along this line, often I get the feeling that men like Mr. White want to be stopped by staff or someone before the fight gets out of hand. Men like Mr. White start a fight and don't seem able to get themselves back under control but don't like it when it happens. Even though they wouldn't admit it, they want someone else to exert the control they can't.

Dr. Goldfarb: Arguments and fights between residents may be a special problem here in the institution and different from a similar kind of occurrence between neighbors out in the community. *First,* in an institution where residents live together, there are no structural and temporal divisions in the day as there are for us.

Residents lack compartmentalization of daily activities. Also information travels quickly from person to person or department to department. Because many of our rooms are for multioccupancy and bathrooms are shared, even the resident's room isn't very private. Thus behavior which might be accepted so long as it is done in private, here is public.

Second, the residents and patients are old, and it's probably not good for them to lose their tempers, and physical injury is a risk. Excitement, sudden physical exertion, and danger of falls are real.

Third, old people are here for protection and care and expect staff to protect them against abuse by their fellows and from their own excesses. They can expect us to help them to not lose their tempers, to avoid doing or saying things which not only hurt others but hurt them socially, and about which they may feel ashamed or guilty later.

You have made clear that arguments and fights are unacceptable in the Home for at least these reasons.

Can we understand why Mr. White behaved in this anti-social way? What kind of a person is he? What preceded the outburst?

Social Worker: I'm his social worker. The two main things that struck me about him right from the beginning were his forgetfulness—he kept repeating the same stories over and over again—and his quick temper.

Dr. Goldfarb: He's always been short-tempered? By whose account?

Social Worker: His own, and confirmed by his doctor who helped him come into the Home. His wife died in a mental hospital the year before he came here, and they had no children or other close relatives—just the doctor and a couple of men he had worked with. He was a very successful salesman in his day, and the stories he repeatedly told us were all about his business successes.

Nurse: He's moved around a good bit in the 2 years he's been in the Home. First in a room for three in the cottage, and this year three different room assignments in the infirmary.

Social Worker: He had a terrible time with his two roommates in the cottage. He set the rules in the room, and he yelled and brandished his cane when things didn't go right for him. He never hit anyone, but the roommates complained about him, and asked us to move him to another room. We tried to talk to him, but he wouldn't listen to anyone—staff or resident.

Nurse: There haven't been any serious problems between Mr. White and his various roommates in the infirmary. The room changes came because of changes in his health status. He came into the infirmary with a bad upper respiratory infection and high fever followed by an acute brain syndrome episode. There is the additional diagnosis of A.S.H.D., and when the acute brain syndrome subsided, it was decided that he should remain in the infirmary permanently.

The first room change was from a maximum medical care unit to a minimum care unit. Two months later we transferred him to a different minimum care unit. There are more men in this unit, and we hoped he would participate in the activity program and relate more to other patients on a unit where the female/male ratio was better.

Chaplain: I have been listening and thinking how differently patients appear to different staff members—depending, I guess, on the particular job and background of the staff member.

None of you has mentioned that Mr. White is a very religious man; he comes regularly to services and seeks me out to talk. He told me also about his bad temper; he talked about his battles with his cottage roommates, and he says he has never actually hurt anyone.

I don't see him as unaware of the wrongness of his behavior or as unwilling to talk about it, as the social worker and his cottage roommates did. Except when he is in one of his rages, I find him a very nice man and several times, out of respect for me, as the Chaplain, he has quieted down when I asked him to.

Now, in his declining years, he says he has nothing, and when he dies, nothing

will be here to show that he lived. His wife's breakdown and her dying in a State Hospital are terrible memories for him. And no children to comfort him now and to be here on earth after he is gone.

Also I remember what Mrs. Harris said about people here in the Home not knowing the person she was. Mr. White feels this strongly. He was a very successful salesman, and highly regarded in his company. But that was some time ago; and about 5 years ago, the company was absorbed by a bigger firm. So none of the owners or top staff from his time is there anymore.

Social Worker: When Mr. White was admitted he told us he had always walked a lot for exercise and "as an outlet." Here, he regularly took long walks both morning and evening. He and Mr. Shore, also a walker and a very quiet and agreeable man, got to know each other and usually walked together.

Nurse: Mr. White hasn't been able to walk much since he came into the infirmary. Mr. Shore does visit him often. They sit together on the terrace.

Dr. Goldfarb: Does Mr. White have other friends? Also about his attack on Mr. Block: Did anything happen to trigger Mr. White's temper? Is there a history of trouble between the two? Did Mr. White ever attack anyone else?

Social Worker: About friends: This was the first time Mr. White came to a Men's Club meeting. At the time for the meeting he was in the lounge near the meeting room and he went in alone. Mr. Block says he doesn't know Mr. White well and there's never been trouble between them. Mr. White didn't say much during the meeting. It was a smooth and relaxed meeting. We were drinking coffee when I heard Mr. Block say something to Mr. White who was sitting next to him about being careful because the coffee was hot. The next thing I knew, Mr. White was trying to hit Mr. Block with his cane.

Social Work Supervisor: The trigger then, may have been Mr. Block's cautioning him about the coffee. Like Mrs. Harris, he sees such remarks not as help but as attacks on his competence. Because he is short-tempered he responds to the attack with attack.

Social Worker: I have seen Mr. White several times since then. He has said nothing about it, and does not seem embarrassed when he sees me despite the fact that he struck at me when I intervened. Maybe he doesn't think he has anything to be embarrassed or apologetic about because his response was provoked by an unfair crack at him.

Dr. Goldfarb: This is quite possible. Brain syndrome may have left Mr. White less able to make accurate interpretations of situations. His background indicates that to be considered successful was important to him. Now here no one knows him in this way his reputation has not followed him and he must also feel frustrated by his decreased ability to establish himself as important. Thus, he may think, "Who does Mr. Block, a nothing, think he is—telling me I don't know how to drink coffee without spilling it? Me, who ate in the finest restaurants in the city. I'll show him I'm no idiot he can talk down to." The ways he has of showing who he is are very limited for him here. Also, his customary response to attack has been to counterattack.

Nurse: Maybe this is why we can't get him to many activities except religious services and programs. He may feel that if he gets close to people they will fail to respect his values—in a sense attack him, as he thinks Mr. Block did, and he will be forced to defend himself to prove his worth.

Dr. Goldfarb: This may be so. He may not feel up to the challenging aspects of social relationships here. Also, he may not be able to handle many stimuli at once. He may tend

to misunderstand what's going on and what is said to him. To be unable to sort the stimuli and respond properly may be particularly frustrating for an ex-salesman whose success was due in part to his skill in these matters.

Recreation Worker: His choice of Mr. Shore as walking companion was a good one, then, because he is so quiet and gentle. He wouldn't make many demands to which Mr. White would have to respond. And I don't think I've ever seen them with others. When Mr. Shore is not with Mr. White, he's often in a group and you know he's very well liked and has many friends. He must understand Mr. White's inability to be comfortable with others.

Social Worker: Then his coming to the club meeting must have been just an impulse. He was right there; there was nothing else to do; perhaps he was bored. Also, the big recognition dinner for the Men's Club was last week, and Mr. White was there. Maybe he figured he was as good as any of the men sitting on the dais who were congratulated and applauded. So when the meeting was announced he remembered the dinner and decided to give himself and the club a try.

Dr. Goldfarb: Your speculation does not sound farfetched. If we talk in the terms we used in our discussion of Mrs. Stone and Mrs. Harris, I would categorize Mr. White as a pseudoindependent dependent. He entered the Home telling over and over again about his success as a salesman and was unable to tolerate his room for three, where he was not the kingpin but the newcomer. He now has two sources of satisfaction—religious services and twice-a-day walks with a companion, Mr. Shore, who respects him and doesn't challenge him.

Then he becomes ill. When the worst is over, he finds himself on a new level—more forgetful and less "sharp" than before, impatient and quicker to temper than before, and without the safety valve and gratification of his long walks.

While he avoids situations that are too complex for him to handle he still longs for people to know what an important person he is or was. This desire is fanned by the Men's Club Dinner and when by chance he can go to a club meeting with no expenditure of effort, he does so.

You said he was quiet during the meeting. Perhaps he hoped to be recognized, deferred to, or called upon by the worker or the members. But he was just a newcomer, no more important than anyone else. So he just sat there and was possibly angry at not being accorded the respect he thought his due. When Mr. Block spoke to him with what was meant as friendliness, he felt he was being underestimated as one who couldn't drink coffee without spilling it and he exploded.

What kind of help did Mr. White need from the worker?

Administrator: I read the worker's report. I think he did all that could be done for Mr. White at that time. He stopped him before anyone got hurt, and he got him to the infirmary unit where the doctor and nurses could calm him down. I'm not as sure that the other club members got the help they needed from the worker.

Social Worker: I haven't sought Mr. White out since the meeting. But I have seen him several times in the lounge or when I'm on his unit. I make a point of greeting him, ask how he is, and he responds pleasantly with no discomfort that I can see, and with no reference to the Men's Club or what happened. I haven't brought the

subject up because I haven't been sure what I should say. Also, I don't know whether to encourage Mr. White to attend the Men's Club meetings after this.

Dr. Goldfarb: Is there something you think needs to be said to Mr. White about what happened in the meeting?

Social Worker: That night I thought that I should see him and reassure him that he needn't feel guilty about what he did. And of course, the other men wanted me to see him and tell him he could come back only if he made a full apology.

But the next day when I saw him, as I said before, he didn't mention what happened. He didn't seem uncomfortable with me; so I wasn't going to start by saying something like, "There's no reason for you to be upset about last night."

Dr. Goldfarb: *Should* Mr. White feel guilty or apologetic?

Physical Therapist: I don't think we would want him to feel he's committed some terrible sin, yet I don't think we want him or anyone else to think it's okay to fight like that. It's not easy to know what's right. After today's discussion I can certainly understand why Mr. White blew up. It wasn't crazy or anything; it was just that he misunderstood Mr. Block. But even understanding this, it still isn't good for anyone to have Mr. White blow up like that.

Dr. Goldfarb: You believe that if anything is said to Mr. White, it would be along the lines of, "Mr. Block didn't mean to offend you, but we can see why you'd be angry if he had said what you thought he did. No harm's done, and we know you'll try not to let your temper get away from you again." In this we're not "reading the riot act" to Mr. White, and yet we're not condoning his behavior.

We understandably feel that people must recognize there are expected standards of behavior here. Maybe our approach should be to have high expectations that residents will behave appropriately, and will be considerate of each other. But along with high expectations is our understanding that at times people can't meet them. "To understand all, is to forgive all," as Albert Schweitzer said. Which means we prefer not to respond in a punishing, angry way. We can understand how Mr. White could feel that Mr. Block was attacking him, and can understand his response, even though we hope it won't happen again.

Nurse: This seems right for this situation because I don't think Mr. White would really try to hurt anyone. I know it looks as if he meant to, but as far as we know he's never passed the cane-brandishing and yelling stage.

Yet the men may not be satisfied if this is all we do. I am afraid that they will feel frightened if we don't seem to be doing things to protect them. Also I think there are women as well as men who may act out some of their anger if they see that people who do this don't get punished for it.

Dr. Goldfarb: When we began, you said that it was hard for you to understand why people here in the Home behave as Mr. White did. You seemed to feel that residents of the Home lose their tempers more often than do adults in the community. Is this so?

Administrator: It seems to be a fact that old people have lost their tempers and curse and hit from time to time, and something like Mr. White's attack on Mr. Block is not a rare occurrence.

Nevertheless we're disturbed by fights among the residents. They are a problem to us. We don't seem able to accept this kind of behavior, because it changes our idealized image of old people—they're not what we think they should be. Is there a little bit of the child in each of us, the child who was taught to respect

the old, and who can't imagine old people fighting for perfectly usual petty reasons because they're angry, hurt, frustrated. It is true that I have often said that I couldn't understand what makes residents fight like this. I guess what I was really saying was I can't believe that old people do such cruel and hostile things to themselves and to each other. But I see it, so I have to believe it. It's hard for all of us to believe that it's not unusual. We must remind ourselves that old people remain human beings.

Dr. Goldfarb: Yes, this is important to remember. Staff is also disturbed by fights between residents because of the possible impact of such occurrences on other residents. Let's begin our next session with a discussion of this aspect of our concern.

Session VIII

Individual Behavior and Special Problems (Continued)

Dr. Goldfarb: What were the reactions of the other men to Mr. White's attack on Mr. Block?

Social Worker: They were waiting for me. Mr. Hahn was in a rage. He said, "Well, now we've got another nut to watch out for." Mr. Sacks said he had known Mr. White for many years before they came to the Home and that he had a temper but since he went into the infirmary, it's been worse, and that he's changed.

Mr. Kaye said, "With what's been going on lately, you can't even say hello to someone without worrying that he'll take you wrong and slug you." When I asked what had been "going on" he referred to other disagreements between residents.

Mr. Hahn, Mr. Kaye, and Mr. Block himself talked about how attacks like this should be prevented, and that they didn't think the Home does enough to protect "the innocent by-stander." Mr. Hahn said that all the doctors will do is to tap Mr. White on the wrist, and next week he'll hit someone else. He understands that some people get old and don't know what they're doing; he wasn't "saying they should be kicked out." But he wanted to know what the Home was doing to keep "the wild ones" calmed down, and if necessary isolated from us normal ones.

If Mr. White comes to another meeting, Mr. Block wants me to tell him "what's what." And if he doesn't like it—"Out!"

I have the impression that the men are scared—not just of Mr. White, but because they feel there are too many residents like Mr. White who may just suddenly blow up and strike out at them. And they ask, "What are you going to do to protect us?"

Dr. Goldfarb: What was your answer?

Social Worker: I asked Mr. Hahn and the others, "What do you think we can do to make you feel less frightened?" They didn't answer except to say that they didn't think Mr. White should be kicked out. Mr. Kaye thought Mr. White should be publicly reprimanded in front of all the residents. He also suggested a kind of probation and taking away of privileges.

Recreation Worker: You know, Mr. Kaye himself is a very angry man. At least this is the way I see him. He tells people off in the lounge and in the bingo games regularly, and for the least little thing. Maybe he's really upset about his own temper, and worried about whether he'll get like Mr. White. Could he want to be sure that staff will step in and stop him if he starts hitting? Or is this a reaction against his own angry feelings?

Administrator: We often take at face value what a few Men's Club members say, without asking, "Is this an accurate description of reality?" or "What purpose does this man have in saying these things to me?" If they're frightened, their expressed fear is not always realistic. The fear of attack may not be entirely related to what they saw.

They do seem to have fears which easily surface. They fear the irrationality of others around them and that staff may not be vigilant enough to protect them. Is it possible that Mr. White's attack gave them a chance to air grievances about the Home, to complain about being here? Maybe they really want a chance to gripe. Maybe they weren't asking you to do anything but hear about these fears.

Dr. Goldfarb: If we follow your line of reasoning, can we assume they were not right that Mr. White suddenly attacked Mr. Block "for no reason," and that Mr. White is not "a nut"? Also, are there a number of residents who behave like Mr. White? Is it true that residents run a risk of being targets of irrational, unprovoked attacks by residents who suddenly run amuck?

Physical Therapist: I'd say neither assumption is true. Mr. White at times misunderstands situations. This may have led him to strike at Mr. Block. A mistake is not the same as irrational, unprovoked, random behavior. Residents so rarely strike out at each other that risk of injury is slight. It's true that recently one man pushed another who fell and broke his hip. I can't remember any other such incident.

Dr. Goldfarb: Perhaps these men are angry people who are behaving in a way similar to Mrs. Stone's putting pressure on the nurse. At first what they ask sounds rational and reasonable, "Protect us against the crazy ones." But how dangerous is our Home for its residents? When we ask, "How many homicidal maniacs do we have?" their plea for protection suddenly loses some of its urgency.

Occupational Therapist: It does seem better to let the residents air their gripes, ventilate their fears instead of rushing into action quickly. Would a special meeting of the club at which it might be possible to talk about the incident be wise?

Sheltered Workshop Worker: In that meeting could we help them see the reason for Mr. White's behavior? Would it calm them to explain that Mr. White misinterpreted what was happening, and that his response was to what he thought was an attack?

Dr. Goldfarb: I doubt that this would help. No matter how carefully you worded it, Mr. Block would feel that you were blaming him and his reaction would be to defend his actions. He might say something like, "What could I do? I see this man—very shaky and the coffee so hot. So I did what any responsible person would do to help. I said to him, 'Take care, Mr. White, the coffee is hot.' " And even if this didn't happen, there's something else. We're trying to help them see that an inoffensive remark can be taken wrong. But isn't it really too much to expect that everybody should be on their guard lest they say something that someone might misinterpret?

Chaplain: But, Dr. Goldfarb, it would not be our purpose to put them on their guard like that. Instead we would explain Mr. White's misunderstanding so that the men could see that Mr. White isn't crazy.

Dr. Goldfarb: If we decide that it would help the men to talk about what happened, then you would want to help them understand Mr. White's behavior. But I don't think we'd accomplish this by explaining what Mr. Block's remark meant to Mr. White. It's easier to think about what the worker should do now than when you're the worker and in the midst of a discussion. But instead of giving an explanation, the worker might have asked, "I wonder what happened to Mr. White. That was a difficult situation, wasn't it?" or perhaps, "He must have misunderstood something. Was anything said that he might have misinterpreted and got upset about?"

Chaplain: Dr. Goldfarb, you said, "*If* we decide that it would help the men to talk about what happened." I gather you don't really favor such a discussion.

Dr. Goldfarb: This is not a question for which there is a categorical *yes* or *no*. Even if our understanding of what happened was complete, there would still be some room for disagreement about what should be done. Perhaps it would have been best if the worker could have stayed around longer than he did that night and have encouraged more discussion.

I doubt that this would have been good. I feel that the less we talk about this kind of a situation with the group the less danger we run of making it a bigger issue than it really is. I think the worker could say something like, "I'm glad I was here with you to see what happened. We'll have to find out what's wrong with Mr. White." I would try to acknowledge that something happened for which they had needed help, that harm was done, that things do happen, and that there are explanations for such events which we can find out about and which can help us avoid or control them.

Social Work Supervisor: These situations are particularly difficult in an institution because they tend to be talked about, and too much talk can make a minor problem into a major crisis. But in this case, I'm not sure Mr. Hahn would quickly let the matter drop. He seems like the kind of person who will hold to his belief that Mr. White is crazy, yet in a contradictory way also insist that Mr. White be publicly punished.

Right now, Mr. Hahn seems eager to create a crisis. He has never forgiven his daughters for putting him here, and is always looking for things that are wrong with the Home. Then he tells his daughters and makes them feel guilty for bringing him to such an awful place. I'm sure he has told his daughters that he's surrounded by wild men and that the staff can't control them and just sits by and does nothing.

Dr. Goldfarb: Here we see again the kernel of truth in the words of the paranoid. Mr. Hahn's view of the situation is not a complete fabrication, yet he is right for the wrong reasons, his own reasons. Except under group therapy circumstances, a full dress discussion of Mr. White and what happened isn't likely to help Mr. Hahn and the others understand either Mr. White's or their own behavior better. We have the additional problem of Mr. White's feelings and rights. Should he be invited to such a meeting? How would he feel about a public discussion of him—whether he's present or not?

I fear all we would accomplish is to make the situation bigger than it is.

But you may doubt that Mr. Hahn will be stopped by efforts to treat the situation matter of factly. Someone might mention Mr. White at the next regular Club meeting and might say, "What do those doctors mean letting a nut like Mr. White out?"

It may be important to work with Mr. Hahn to help him feel less angry and desirous of confrontation. But this should be between Mr. Hahn and his worker, not in the context of the Men's Club.

Chaplain: Would you try to close the Men's Club conversation off?

Dr. Goldfarb: No. We must be willing to talk with residents about things like this if they persist. But we try to discourage wild flights of fancy—in this case, Mr. White is not "crazy" and residents are not in constant danger.

However, we must hear their complaints. Residents usually have complaints

about the Home. They've got many personal reasons to do so. Mr. Hahn's complaints about his daughters' having placed him here have been displaced by complaints about the Home.

Any incident can become a lightning rod for these complaints. But the incident is often only remotely related to the resident's real complaint. It probably makes better sense for the staff to try to help Mr. Hahn with his problems than for us to let continued discussion of Mr. White make a major problem out of a relatively unimportant event.

Recreation Worker: Don't you agree that some residents are afraid of their own anger and want to be sure that staff won't let them lose control? I think this is why they want staff to move in firmly and why they seem punitive in their approach to Mr. White.

Dr. Goldfarb: This approach doesn't completely explain the punitive, authoritarian approach some of the men recommend. Maybe as we get older and have less time and energy to deal with complex human problems it's easier to say, "Tell him not to do it, and if he does it again, isolate him."

We ourselves often become impatient and want clear "guidelines" for action instead of discussion and seeming ambiguity. If we feel this way sometimes, we can see why the residents don't want to bother with searching for answers but want immediate solution and action to prevent troublesome situations.

Administrator: Residents may be like Americans who can't understand college unrest or black power movements. Feeling helpless in the face of behavior which violates their ideas of what should be, they want the kids punished no matter what and they want violence to stop even if it means more violence!

Dr. Goldfarb: There is a similarity. So staff must try to preserve a proper balance and to deter old people from dealing punitively with each other. They probably say punish or isolate because they feel that they have less time and energy to discuss, to think, and to work on finding solutions to these seemingly urgent problems.

It's up to us to understand what lies behind their press to action, to their punitive approach and ourselves to avoid being punitive and blaming.

Physical Therapist: There's still the danger that residents, their families, or board members will feel that we're condoning Mr. White's behavior unless we take a "stand." They may feel that we're saying that because Mr. White's feelings are understandable, it's also understandable that he tries to hit people.

Dr. Goldfarb: I think we can avoid such a misunderstanding of our position in this matter. Remember the worker did stop Mr. White and remove him from the room. This should be clear evidence that we do not permit one resident to attack another, and that we will protect residents under attack. But we must not allow ourselves to be pushed into believing that we're condoning behavior if we don't punish it.

Here again the staff has to introduce a reality-based balance into the picture. It's important that the residents' right to protection and their right to understanding and care are equal. But neither of these rights depends for their existence on a punitive approach to the occasional unreasonable behavior of some of the people in the institutional community.

Next session let's tackle the problem situation created by the male patient's sexual advance to the lady in Occupational Therapy, because some of these same factors operate in that situation also.

Session IX

Individual Behavior and Special Problems (Concluded)

Dr. Goldfarb: Let's continue talking about behavior which creates special problems for the individual in the patient community. You described what appeared to be a sexual advance by one of the male patients to a lady seated next to him during an Occupational Therapy session. What made this situation a problem? And to whom?

Occupational Therapist: My staff certainly viewed it as a problem. We don't understand why a man like Mr. Kaye would suddenly—in the midst of a room full of people—behave this way. We don't expect a man to open his fly, expose himself, and try to fondle the lady sitting next to him. And certainly the other patients at the table were upset by Mr. Kaye's behavior.

Dr. Goldfarb: This would seem to be precipitous, unexpected, and probably unacceptable behavior under most conditions. However, if Mr. Kaye and the lady had not been in a public place would there have been a problem?

Psychologist: Possibly not. This would of course depend upon the woman, their previous relationship and other factors. However, men often flirt with women in the Home, for example during the Sheltered Workshop sessions. Usually women discourage or ignore those overtures, but I think they would behave differently if there weren't so many witnesses. If the two people weren't in the institution or if they were alone here and behind closed doors, the lady might be more receptive to the man's suggestions. And possibly both might be happier!

Nurse: You're assuming then that the only thing the lady objects to is the audience. Even if this were the case I think if the couple were alone together and other residents knew they were, there would still be a problem, as far as other residents are concerned, and the couple might be aware of this.

Social Worker: You know, we do have a number of couples—not married—who spend most of their time together. And often they are together in privacy. Staff accepts their right to do this even though we know many residents don't approve of these couple relationships, and especially don't approve of any hint of a sexual component to the relationships. Also I think we would prefer that both partners under such circumstances are alert and oriented and that they know what they're doing, and that they should behave "appropriately" in public.

Administrator: This may be oversimplifying the problem. Our residents have little or no privacy. Because of their cultural background they make a sharp distinction between what's right in public and what is all right if it's strictly private. Since there are so few single or double rooms and private baths, with their rigid distinction between what is permitted in private and public behavior, our residents are caught in a bind. They must either always act in acceptable public ways and therefore be unable to do many important, satisfying things or they must violate their own life-long standards and risk giving offense to, and being punished by their peers. They run this risk because they must choose to do "private things" in public, or not do them at all.

Dr. Goldfarb: However, people, even of the same generation and culture may differ among themselves with respect to this matter of what must be private and what may be public behavior. There are undoubtedly considerable cultural differences between what is accountably public behavior. There is no question that for most persons the lack of privacy may be distressing.

There is another dimension to the problem. We have many brain-damaged patients. As one of you said, a heterosexual relationship may be acceptable if the two people know what they are doing. But brain-damaged patients may not meet this criterion. You imply that neither person should be a victim who is being exploited or used by the other; a brain-damaged patient is obviously a likely candidate for the role of victim. He or she may easily be a sexual target, or may often just as easily be prompted into behaving with excessive sexual frankness despite public scrutiny.

The distinction between public and private may be a distinction brain-damaged patients can no longer make because of the loss in their ability to remain well-oriented. They may respond to the way they feel when they are sexually stimulated because the feeling leads them to believe that they're at home or in a motel room.

If they think they're at home, if there is situational disorientation because they cannot make necessary discriminations, response to feeling or interest may lead to quite inappropriate action. For example, the man sees that nice, helpful lady in white, and thinks she's his wife. Who else could be in his bedroom, helping him to get into clean pajamas? The nurse may then be surprised and displeased by the patient's physically affectionate behavior and the patient may be unable to understand the negative response to a gesture which his wife accepted without comment.

Occupational Therapist: Brain syndrome, disorientation and situational confusion may explain Mr. Kaye's advance to Mrs. Gordon. He seemed very surprised when the other ladies began yelling, and the aide who took him back to the unit said he seemed bewildered. He asked her why he had to leave or what he had done wrong. I can't remember exactly what he said—just that he didn't understand what was happening or why all the fuss. I feel uncomfortable that some of the staff were amused by Mr. Kaye's surprised reaction. It was as if he were a kid caught with chocolate cake crumbs on his face, but denying that he was the one who ate the cake his mother was saving for company.

Social Worker: I'm glad the subject of staff being amused by patients' behaving in a sexual way had come up; jokes about the sex lives of the old are pretty common in our society—look at the dirty old man bit week after week on "Laugh-In." Often the joke is about the man wanting sex, but being unable to perform sexually anymore. Or if the man is portrayed as still sexually active, there's a kind of condescending humorous applause for unexpected prowess.

We probably bring these attitudes to our jobs. Even though we may know better professionally, general cultural attitudes still affect us in our work. When I first heard about Mr. Kaye's behavior, I think I pretty much dismissed it as a kind of dirty old man bit, and I didn't think much more needed to be done than to get him away from Mrs. Gordon and to protect him from the wrath of Mrs. Silver and Mrs. Brown who I know see themselves as the "Keepers of the Public Morals."

Dr. Goldfarb: What we had said about the fight in the Men's Club may hold true here as well. Right and wrong or approved and disapproved behavior are social definitions which vary with culture.

Sexual behavior in our culture has been subject to many controls which may be lost or broken through with aging, brain damage or dysfunction. Our attitudes about sex tend toward discouraging a belief that sex after 70 is necessary or even possible. If we grant its existence we may not approve of it; sexual interest or behavior in old people may be regarded as not quite nice or normal.

We do have some special factors here in the institution which add complexity to this already difficult problem. We've talked about the lack of privacy which forces on patients an unhappy choice between doing private things in public, or being unable to do these things at all.

We've talked also about our brain-damaged patients, and recognize that sometimes the sexual component in their behavior may reflect a loss of orientation, as well as inability to discriminate between appropriate and inappropriate behavior or to choose wisely the locale for or the object of a sexual advance.

Also brain-damaged persons present quite a special problem in that they really are not able to enter voluntarily, and with full knowledge, into a relationship with another. Staff therefore have the obligation to protect some of these patients from sexual exploitation. This means that we can't always mind our own business as we might outside the institution. Yet this does not mean we should be prudish monitors or sexual segregationists.

Occupational Therapist: In this situation, we had Mr. Kaye who, according to the record, has been diagnosed as suffering with a moderate degree of brain syndrome. He is unable to maintain his orientation and has poor judgment. Mrs. Gordon is severely impaired mentally. She seems unaware of what's going on around her most of the time.

Dr. Goldfarb: Both of these patients appear to need protection. Mr. Kaye against the jeers and punishment of his peers for acts he may perform which connote something other than was intended or for acts he would not perform if he had better ability to control his impulses. Mrs. Gordon needs protection because she doesn't know what's happening, cannot move away, and therefore may be used as a target or object in ways she does not understand.

Social Worker: I'm not so sure Mrs. Gordon is such an unwilling victim. I'm her social worker. She was married and widowed four times, and even here in the Home and in her 80's, was a very sought-after lady. Despite brain syndrome she still is vain about her appearance; even though she has to be helped to bathe, dress and to be madeup. As male staff members can tell you, she still reacts to men in a flirtatious way. The occupational therapy staff did not describe her response to Mr. Kaye's advance or what led to it. Perhaps the advance wasn't entirely unsolicited, and if not solicited, it may not have been unwelcome.

Chaplain: Let me tell you some additional things about Mr. Kaye. He and I had many talks when he first came here. He told me that he was very active sexually when he was a younger man, and that the strength and frequency of his drives was a problem to him. He's a religious man, who feels a terrible sense of sin—not that he ever sinned very much in the sense of infidelity to his wife, and even about infrequent "affairs" after her death. Also he always masturbated frequently; this plus his preoccupation with sex are the "sins" which were his burdens.

I don't know whether, in this situation with Mrs. Gordon, he knew what he was doing and where he was. I do know he has masturbated in public—in the unit lounge, for instance, and has recalled it later and felt very guilty about it. I know, also, that he and Mrs. Gordon are often seated near each other in the lounge, or in

the unit dining room. But I don't know whether this is by chance or because they have a kind of special relationship.

Dr. Goldfarb: Now our picture of Mr. Kaye and reasons for his behavior are becoming clearer. Mr. Kaye's judgment is impaired and he has decreased ability to restrain his impulses to behave sexually.

Persons who lack ability to restrain themselves may regret their actions, as Mr. Kaye often does. Many may not have sufficient cortex left to recall or to regret unseemly behavior. This may now be true for Mr. Kaye, hence his surprise at being removed from the occupational therapy room.

With Mr. Kaye, there is also the special factor of the strength of his sexual drive. People do differ in this, and apparently Mr. Kaye, even though 84 years old, still experiences strong and frequent sexual tension. Another old man with a similar loss of inhibitory capacity but with weaker sex drives would have little to inhibit. Therefore the loss of inhibitory capacity would not create interpersonal problems for him as it does for Mr. Kaye.

What you have told us about Mrs. Gordon helps us understand her role in this situation. It sheds further light on Mr. Kaye's behavior, and suggests that he may have exercised some good judgment in his choice of sexual object. Mrs. Gordon no longer seems entirely a victim in the transaction. If a victim, she may have invited victimization.

Social Worker: Nevertheless, for us to understand these two people and their sexual relationship better doesn't make their behavior more tolerable to other residents. Weren't the occupational therapy staff quite right in putting a stop to Mr. Kaye's public love making?

Dr. Goldfarb: Yes, because we see that Mr. Kaye and Mrs. Gordon are endangering themselves. We know that both are brain-damaged, and not really aware of their responsibilities, obligations, and social duties. However, their neighbors are less understanding and will be less forgiving. Not knowing Mr. Kaye as we, they may think of him as a dirty old man, a pervert, a menace.

We do need to be protective of both Mr. Kaye and Mrs. Gordon. We have to help make up for Mr. Kaye's lack of inhibitory capacity, and for Mrs. Gordon's disorientation. This does not mean that we view them as "geriatric delinquents" who have done wrong or who have given offense to those around them.

Why did Mr. Kaye behave in a seemingly incomprehensible and intolerable way? That he's "a dirty old man" is no answer.

Our search for answers took us to Mr. Kaye's memories of himself as a young person and a married man. They took us to each of you who knows Mr. Kaye as a particular kind of man. And then the answer made us look again at Mrs. Gordon, the other person in this human transaction.

Now although our answers have helped us understand and to forgive, you point out that staff responsibility may press us further. Although we forgive all we cannot permit all. Your administrator might say it differently: we must draw the line somewhere.

What does your insistence on drawing the line connote? Are there some situations and problems we can't handle without being punitive? Granted, we do not think the behavior is delinquent or anti-social or morally reprehensible. If it is behavior that endangers the individual or the people around him, are we forced to special action? You remember that with Mr. White we could only be of help by removing him from the danger of his confrontation with Mr. Block. This meant taking him to the unit where people knew and understood him.

Similarly here, it would be senseless cruelty to sit by forgivingly and let Mr. Kaye and Mrs. Gordon behave in ways which damage them in the eyes of their peers. We take Mr. Kaye out of the situation which he can't handle, to help, not to punish, and we try to convey this message to other residents and to staff.

Occupational Therapist: I agree that this approach is the best as far as Mr. Kaye and Mrs. Gordon or Mr. White are concerned. Still I'm not sure this helps the other patients. They have reacted emotionally to the event and look to us for something to help them.

I'm not defending Mrs. Silver or Mrs. Brown. They do see themselves as the consciences of this community . . ., and when I listen to the two of them sitting in judgment on everyone, I think what fun they would have had burning witches in Salem a few hundred years ago.

Nevertheless many residents feel the way they do. They think people like Mr. Kaye and Mrs. Gordon should be kept isolated from the other residents. It's not that they want them punished, and it's not like Mr. Hahn and his fear of Mr. White. Their perception of themselves, in some way seems to be threatened by Mr. Kaye's behavior.

They seem to feel they're in the same boat with someone like Mr. Kaye. They are upset to find they've sunk so low that they're ending up in what Mrs. Silver calls "The Looney Bin." Being here is hard enough for them. They feel they have lost much when they were forced to come here. They have pulled themselves together and being here is bearable when they create a special enclave for themselves.

They form a group of "Dowager Queens" who do get some special privileges because of leadership roles and volunteer work. Mrs. Silver tells board members and important visitors that this isn't an institution. "It's like a resort or a residential hotel," she says, with conviction. If the Home isn't as good as a resort, "then what am I doing here?" Since her children want only the finest for her, this must be the finest.

Some of the other "Dowagers" are like her. Some are more realistic about where they are. They don't redefine the Home the way she does. Instead they try to ignore the things they don't like, and they maintain a distance from other residents except their own group.

It's hard for them to ignore Mr. Kaye's exposure of himself and it's a particular threat to Mrs. Silver's definition of this as a resort. I think Mrs. Silver deserves as much understanding and forgiveness as do Mr. Kaye and Mrs. Gordon—maybe more, because she knows her situation, and hates it. She needs to know that just because she's here, it doesn't mean that we see her and Mr. Kaye as alike; and just because he's here, it doesn't mean that this is a Snake Pit and anything goes.

Administrator: Isn't this situation similar to the one with Mr. White? We agreed that stopping Mr. White's attack would protect him and also assure the others that though we don't punish, we also don't permit one resident to assault another. Same thing here: we do ask Mr. Kaye to unhand Mrs. Gordon and zip up his fly and we do remove Mr. Kaye from that session.

So Mrs. Silver and the others see that we don't think this is "A Looney Bin," nor do we believe anything in the way of inappropriate or bizarre behavior goes. But at the same time, we know that there are reasons why residents behave the way they do. We know Mr. Kaye is not a dirty old man, and we're not going to treat him as if he were—which means to punish him.

One more point. I am not questioning your picture of Mrs. Silver and of the means she has used to make being here endurable. But you've left out her strength. She can act as if this is a resort, and at the same time, she knows the knowledge of the real institution is hers, to be called upon if need be. I don't really think Mrs. Silver's ability to bear Mr. Kaye's behavior is as fragile as you believe. Nor do I think it necessary to punish Mr. Kaye in order to shore up Mrs. Silver's definition of this as a resort.

Dr. Goldfarb: Our approach relieves us of the necessity to decide whether Mr. Kaye or Mrs. Silver has first claim on our understanding, forgiveness, and help. We need not decide whether we must forgive Mr. Kaye because we understand him, yet must punish him to help Mrs. Silver maintain her belief that this is a high class hotel for refined gentlemen and ladies.

Staff must appear to expect high standards of behavior from our residents and patients yet be accepting of behavior that falls far short of the standard. When Mr. Kaye comes to the lounge with his fly open and his penis exposed, he is not meeting our expectation that everyone is completely dressed. However, we understand that old people may forget to check whether they are zippered before they leave the men's room. So when we see Mr. Kaye unzippered, we act to help him get himself in order. Thereby we acknowledge that our high standards may not be met, and we are tolerant of failure and ready to help.

With Mrs. Silver and Mrs. Brown, our approach would be the same: "Yes, I can see you're upset by what happened. I'm sure Mr. Kaye did not mean to offend you. He's in his room now, and the doctor was on his way up when I left. Mr. Kaye will get whatever help he needs; so we don't need to worry."

We may acknowledge Mrs. Silver's feelings; affirm that sex in public can't be permitted in this setting; present Mr. Kaye as one who would agree with us in this matter; and therefore, since his behavior was not consonant with his standards and beliefs, we must find the reasons for Mr. Kaye's behavior; and this understanding will enable us to help Mr. Kaye with his problem.

Note that we began with a seemingly "geriatric delinquent" whose behavior we couldn't understand; with two witch-burning ladies, from whom our delinquent needed protection. They have been replaced by an individual we now know better and think we can help and by two ladies who need to be understood and to be helped to understand.

Session X

Depression: A Common Complaint

Chaplain: Yesterday I visited infirmary patients. With some, it's an exchange of greetings; with others, there's much to talk about. Forty patients yesterday, and so many of them—at least 25 to 30—depressed, unhappy, hopeless.

I know from our discussions and my reading that depression is common among the old, so this is no surprise. But I kept asking myself, Does it have to be? Isn't there more we could do? We do something about physical pain. Mental suffering also hurts, yet we do not seem to respond to it in the same way.

Dr. Goldfarb: For the most part we've been talking about psychological disorders of the aged as problems of adjustment to an institution and the people in it. The Chaplain is asking that we shift our focus to a particular psychological disorder, depression, as the individual experiences it, and to consider the care and treatment of the depressed patient.

A "depression" is an affective disorder, a disordered mood. Depression is not the only mood disorder. Manic disorders are also affective disorders. Also the term "depression" can be applied to disorders which appear to be genetically determined—"programmed into" the person—and which occur periodically. Such recurrent disorders may be called "mood cyclic disorders." The cycle may be recurrently depressive, recurrently manic, or alternating. Mood cyclic disorder is probably more common than generally believed. Also there are "depressive reactions" probably of various and multifactoral origin. Depressions, whatever their type, are very common in old age.

One more point: Disorders of affect may exist in combination with other psychiatric conditions. Many of our patients, for example, can be categorized as suffering chronic brain syndrome with depression.

What does the depressed person feel? What does he complain about? How do you know that a patient is depressed? What are its signs?

Chaplain: To me they seem resigned, but not with a good feeling. It's like trying to come to terms with yourself and your life, but with bitterness and resentment. Mr. Weiss, for instance, whose leg was amputated 3 weeks ago—I saw him last just before he went to the hospital, when the doctors still hoped the leg might be saved. So today I expressed my regret that our hopes had been in vain, and he just shrugged his shoulders and said: "I knew it would be this. Why should I expect anything good now? I've had nothing but bad all my life."

Physical Therapist: Well, you couldn't expect Mr. Weiss to feel differently so soon after the operation. But some of our patients cry about things that happened a long time ago—like Mrs. Jacobs. The doctor prescribed physical therapy for her last month. She's not a new resident, but I didn't know her before. I couldn't get her to try anything; nothing worked. I never saw her smile or heard her say a good word. I asked her, "Don't you want to be able to walk without worrying about falling? You don't

want to be in a wheelchair, do you? Why are you so sad all the time? Can't we help?"

So she told me about her husband's death—about how happy they were and how close their relationship was. She just can't stop missing him. She knows she has to make the best of it. She doesn't want to be an invalid in a wheelchair—she'll try.

I go out of my way to give her all the support and recognition I can, but no go. We're getting nowhere. I checked her social worker. Maybe she's got some ideas. Ideas, no; but a surprise, yes: Mrs. Jacob's husband, her social worker says, died 20 years ago!

Twenty years! But her grief is as if it just happened. She's not faking it; she really is depressed and still in mourning.

Nurse: In a way, though, I don't worry as much about the Mrs. Jacobs as I do when the patient's depression seems beyond talking or tears. The ones who just withdraw from everything and everyone. It's like they are shriveling up inside themselves. Think of little Miss Green on Station 5.

She just sits in her room all day. Of course we get her to get up and dress in the morning and to go to the dining room at mealtime. But I think if we let her alone, she would just lie in her bed until she dies.

With her, you get the feeling of total resignation. She's like Mr. Weiss in one way. She's had a very hard life, and she also says there's no reason for it to become good now, when it's almost over.

But with her, there's nothing like Mr. Weiss' anger or resentment. It's as if she thinks she deserved nothing but misery, so what right does she have to complain. Mr. Weiss says he doesn't expect anything good, because he's never had it otherwise. But he doesn't say that he deserved this kind of life. Just the opposite: he talks about how hard he worked for his family and how he helped other people. And he's angry because he's been dealt with unfairly. He deserved better. Miss Green didn't, so she has no right to feelings of anger or resentment.

Her outlook is utter bleakness, and nothing we do makes it any better, no matter how we try.

Dr. Goldfarb: I'm interested in your comparison between Mr. Weiss and Miss Green and Mrs. Jacobs. All are depressed, all speak of feeling hopeless.

But there is a difference. There is anger in Mr. Weiss who feels he doesn't deserve his bad luck. Miss Green doesn't feel angry. She says she's gotten what she deserves—that all is lost. But she's not mad, because the outcome is fair.

Occupational Therapist: When something bad happens and it's the person's own fault, we say, "Well, she has only herself to blame." Doesn't that mean she can't be mad at anyone except herself?

Maybe Miss Green is just as angry as Mr. Weiss is about how hard her life has been. But he blames people or things in the external world for his bad luck, so his anger is at the world, and therefore, is clearly evident to us. But Miss Green's anger is at herself, and so being kept inside, it's hidden from our view.

Dr. Goldfarb: Yes, anger is always present in depression, albeit sometimes disguised or hidden from our view, as in the case of Miss Green. Psychiatrists call anger turned against one's self *retroflexed rage*. You said that if left alone, Miss Green would simply let herself die. Suicide can be the aim with retroflexed rage. It can result from a gradual process or be the consequence of a single violent act, as is the more typical

suicide. People who commit suicide, among other things, are murderously angry at themselves for being in their terrible situations; they are also angry with the people who they feel should have seen their trouble and helped them out of it. Suicide serves the double purpose of releasing the self from an unbearable situation, and of "getting revenge on the people who should have helped" but didn't.

Later we'll talk more about suicide. We've noted that feelings of "hopelessness" and resignation are common in depressed old people and that "hopelessness" is usually accompanied by anger and resentment toward others and toward one's self.

Are there other feelings or behavior which we recognize as signals of depression?

Social Work Supervisor: I'm thinking of Mr. White and also Mr. Hahn and probably Mrs. Silver and Mrs. Brown. I'm not sure that we would automatically put them on our list of depressed patients, because it's their anger that comes through first and loudest. Not sadness or hopelessness or resignation, and the typical staff-resident contact with these individuals comes because Mr. Hahn cursed out his tablemates or Mrs. Silver broke up the Friday Afternoon Ladies' Club Meeting with her verbal attacks on her sworn enemies.

Our discussion of Mr. White or Mrs. Silver in these seminars is a good example: they came to our attention initially not as people who need our help; but rather as people causing problems in the institution community. It wasn't until later that we looked at their anger as a symptom of their feelings of loss and helplessness.

Mr. White wouldn't describe himself as depressed or unhappy, I don't think. If he complains, it's always about something or somebody in his immediate environment. He doesn't think of problems or bad feelings in himself, and we tend to follow his lead and concentrate on these external facts and ignore the undercurrent of depression.

Occupational Therapist: Aren't the complainers almost the same? They complain constantly; and we get so involved in the complaints that we miss the feeling tone underneath. Like Mrs. Stone, I think the thing we learned from our discussions of her is that her unhappiness is not the *consequence* of the things she complains about. It's the other way around. Her depression is so pervasive that she can do nothing except complain; but as we all know, removing the reason for the complaint doesn't reduce her complaint level, because we haven't touched the depression.

Nurse: Another kind of person I think of as being depressed may be just a variant of the complainer, but we should add this category to the list because it contains so many of our patients. This is the patient who is completely involved with his own health, so that he talks of nothing else and all of his energies go to taking care of himself.

It's hypochondriacal, of course, but it's more than just an excessive fear of illness. It's that he reacts to everything and anything in a kind of somatic way. And he exaggerates and magnifies these reactions.

The typical example among the aged is the very common preoccupation with bowel movements. Sometimes the patient is so anxious and preoccupied with his bowels that he rushes for medication and doesn't give his body time to work naturally. For other patients, the constipation seems their way of expressing their need for help, and their depressed, angry fear of being abandoned.

Dr. Goldfarb: Well, we have quite an array of patterns of behavior, all of which may signal the presence of depression. In some—for example, the "hopeless" ones—the depression is relatively easy to spot. But as several of you pointed out, some of their behavior patterns—the angry, demanding ones, or the self-involved complainers—seem to mask or distort the depressive reaction. Behavior we describe by the terms apathy, pseudoanhedonia, somatic complaining, hypochondriasis, even paranoid, angry or manipulative or explosive behavior may be precursors of and components of a full-fledged depressive reaction. This means that a painful, disabling psychiatric disorder may go unnoticed and untreated; even the sufferer himself may misunderstand his situation and believe that he would be all right if some reality factors were changed—if his body, his circumstances, or the people around him were different.

Nurse: But, Dr. Goldfarb, you talk as if there's no reason for our patients to feel depressed, and this is where I disagree with you. Mr. Weiss, for instance, has been seriously ill—mainly the diabetes—for months. And now he's just recovering from major surgery which has left him with just one leg.

I don't see how he could feel, except depressed; yet we're talking as if his reaction is disordered and abnormal. With Mrs. Jacobs, all right—maybe her active grief for her husband is an excessive reaction. But maybe that's what she latches onto to explain her general depression at being alone and in the institution, and old, and with her health steadily declining. Isn't it natural for her to long for the past and her happiness with her husband, since today is so bleak?

Administrator: Let me say something analogous to what you've just said and see what you think. Among professional football players, injuries are very common. Even with the best of protective equipment and enforcement of rules of fair play, most players sustain serious injury at least once during their careers. Therefore players and their families and the general public must accept injury; and if a player is surprised or complains when it happens, we should wonder about how realistic and mentally healthy he is.

Sheltered Workshop Worker: And taking your analogy a step further: Since injuries are so common and must be expected as part of the game, no special response to or treatment of them is needed—except, of course, getting the player off the field so that the other players may continue the game.

Dr. Goldfarb: Yes, your analogies illustrate well one of the misconceptions which mask depression from both the sufferer and people around her. First, that it is "normal" to react to misfortune or loss with depression that is intense and long-lasting.

Also it is assumed that old age is necessarily and inevitably a time of decline and illness. Which explains why old people have poor appetite, listlessness, and fatigue, difficulty in sleeping, and constipation. Therefore these are ignored because if they are "normal" they are assumed to be untreatable.

Chaplain: Yes, and this attitude toward old people must add to their already depressed and helpless feelings. I saw an example of this yesterday.

Mrs. Miller's son was visiting her. Mrs. Miller is one who complains from morning till night and to everyone she can grab hold of, including this son.

No one is as sick as she; no one suffers as much. She and her son were in the lounge, and I watched and listened. She talked on and on about each symptom, while her son cleaned his nails, watched TV, looked through some magazines.

Finally when she paused to take a breath, he said, "Well mom, you know how it is. You can't expect to be in A-1 shape at your age. And at least you don't have to worry anymore the way I do. Just think of this: I get sick, I can't take off and go home till I feel ok—not with a family to support, I can't. I gotta work, sick or not. But you don't feel well? So, stay in bed. They'll take care of you. Sure, you're 83, so you got some aches and pains. Who doesn't? Even at my age. But look around you at the ones who are *really* sick. You should be grateful for what you've got."

Dr. Goldfarb: There are several painful messages in this son's words. He says pain and decline are the normal concomitants of old age, and, therefore, are to be borne not complained about. Second, he says there is no cure, or even treatment for Mrs. Miller's ailments. Third, since Mrs. Miller is no longer a productive member of the community, her disabilities do not leave a job unfilled or children whose care now becomes a community burden. He implies that improvement in her health status is not worth much to the community, and does not warrant investment of scarce medical resources and personnel.

Administrator: Think how often our residents and patients say these very things about themselves. You ask: "How do you feel?" and the answer is: "Like an old man." Or if someone is ill or has had an accident and a treatment plan is being discussed, patients often say something like: "Why should you go to such bother? How much time do I have left anyway?" I have often thought that the old person says these things because he's gotten the message from his children and other people that this is how he *should* feel. So he complies lest he give people the impression that he's ungrateful or asks too much from life.

Dr. Goldfarb: The message may not be from the children. These are common attitudes in our society: old age is viewed as a period of decline; a low priority is assigned to the aged; work and productivity are viewed as the measures of a man's worth and his claim on community resources. The individual brings these values with him into old age, where they are reinforced and confirmed by the messages and treatment he gets.

Let's backtrack for a moment: we've said that this very common disorder of depression manifests itself in a variety of behavior patterns, and that often the behavior masks the depression. Or even if we do feel the deep sadness behind the behavior, we tend to ignore or deprecate the feelings and deny the presence of any disorder or disturbance in them. Why is this? And what are the consequences of our failure to recognize the depression so many of our patients suffer?

Psychologist: You said something before about the misconceptions that we have about the inevitability of decline in old age, with its corollary belief that disorders that are inevitable are, therefore, not susceptible to treatment.

So if we think there's nothing we can do about a bad situation, we may then try to deny that the situation exists or that it's as bad as people say it is. Or if this fails, we may say we know how bad it is, but since we can't really do anything about it, we shouldn't even show we know about it, since this may raise the hopes of the sufferers.

One example of what I'm talking about: I think we all know that Mrs. Miller is a very depressed lady and that her complaints are constant because her depression is constant and all pervasive.

But most of the time we don't act on this knowledge, but instead our response is to the substance of the complaints.

Social Worker: Or let us be frank, sometimes when we see Mrs. Miller coming, we run the other way, so that we don't have to get involved in the complaints—much less the depression—which I agree, we know is there.

Psychologist: Right, and the important point is our reason for avoiding involvement with Mrs. Miller and her depressed feelings. My example: She caught me in the lounge a couple of weeks ago, but I interrupted her almost before she got started. I told her I was late to a meeting, and I rushed off, practically leaving her in the midst of a sentence.

This happens to all of us: we're rushing through the lounge on our way to a meeting, and residents grab for us and we slow down for a minute to explain our rush, and to suggest another time when we can talk. But I wasn't rushing to a meeting. I was rushing away from her.

I wasn't so comfortable about this. I could feel her depression, but I remember thinking that I just didn't have enough time to listen to all the complaints. And even if I could spend the time today and maybe we did get past the complaints to the sadne and hopelessness underneath, what good would this do? Do I really think we can help Mrs. Miller with her psychological disorders this late in the game?

Even when I do stop and talk with Mrs. Miller, I stay entirely with the substance of her complaints, and I'll knock myself out to try to satisfy at least one of them. And meantime Mrs. Miller and I are saving each other from having to acknowledge the feelings we feel we can't do anything about.

Nurse: Don't we sometimes treat the dying patient the same way? We don't let him ask any questions, and we maintain a cheery, fast-talking pose, even kidding him about how quickly he's going to recover, or about how he's really just faking sickness in order to get out of going to work.

Dr. Goldfarb: The reasons for our avoidance of these matters may be similar, whether it is the reality of depression or of an unfavorable prognosis. What happens if we ignore depression?

Administrator: Well, obviously if we don't see it or choose to ignore it, it's not likely we'll be of help. We'll make no attempt to recognize the causes of the depression, and will neglect using antidepressants or other drugs to reduce the person's suffering. There may be no provision of support and assurance of help which may decrease the person's sense of helplessness.

I guess some patients may just stay on a plateau of depression. Others may get worse, become more withdrawn or more demanding and complaining, or even attempt or succeed in suicide.

Social Work Supervisor: Sometimes isn't there some confusion about reality in the depressive reaction? Can't this be so bad that the patient becomes almost entirely disoriented? And, with our patients the disorientation is assumed to be brain syndrome and irreversible? If so, in the absence of proper treatment, it can become actual brain syndrome.

I'm thinking of people like Miss Parsons. She's always been so dependent and pampered by her older brother and sisters, and their decision to bring her here when her health began to fail was a shattering blow to her. On the brain syndrome evaluation when she came in, the psychologist found a very mild impairment.

But within a few weeks, she was very confused. Remember she insisted that this was a resort where her family used to go years ago, and several patients she took

as members of her family. It did seem she might be in an acute brain syndrome episode. Her family was sure that her confusion was the result of "hardening of the arteries," and therefore, irreversible.

But Dr. Goldfarb's diagnosis was "pseudo dementia," not real confusion, as part of her response to her failing health and the stress related to her admission to the Home. If the diagnosis hadn't been made and treatment given, I'm sure Miss Parsons' impairment and seeming confusion would have led to damaging physical exhaustion or malnutrition and to real confusion which ultimately would have become irreversible.

Chaplain: I don't know whether I'm saying anything very different from what has already been said. You've been talking about the person not getting specific kinds of medication or therapy which in fact act in specific ways to reduce or cure a depression.

The other side of the coin is that the very act of doing nothing confirms to the patient that nothing can be done. The patient becomes more depressed and hopeless, so our sins of omission—our doing nothing—become another cause of the patient's depression, and so a sin of commission.

So even if there is no specific benefit from a specific drug, for example, there may be benefit for the patient because we are not giving up. We are not saying there is nothing that can be done.

Dr. Goldfarb: Yes, remember we talked about the harmful message Mrs. Miller's son's words might convey to her. Similarly, doing nothing may carry with it the conclusion that nothing *can* be done as well as being felt as rejection or abandonment. It may connote that doing something is not worthwhile because the person will soon die. Either way such a message can add to, perhaps trigger, a depressive reaction.

Let me summarize briefly. Depression is a very common psychiatric disorder among the aged. Its symptoms include: (1) insomnia of the early morning waking type; (2) anorexia—poor appetite; (3) changes in bowel habits—constipation or diarrhea; (4) decline in energy, listlessness, easy fatigability seen as decreased spontaneity, inertia, or psychomotor retardation; (5) loss of interest in usual pursuits; (6) a "lowering" of spirits, feeling blue, sad, "down"—usually worse in the morning and perhaps a bit better toward afternoon or evening; (7) "a longing for the bed," early retirement, and quickness to sleep; (8) somatic complaints, fears, expressions of guilt, worthlessness or loneliness; (9) paranoid trends, irritability, vengefulness, spite.

Many of the somatic complaints may be mistakenly dismissed as being due to old age. Also the withdrawn, listless, and uncooperative old person or the agitated, restless, wandering and possibly voluble old person may be mistakenly considered to be confused. There are furthermore many different behavioral patterns found associated with depression, and often the depressive reaction itself is covered or distorted by the particular patterns developed by individuals. Very often depressions become hidden by the complex symptomatology and remain untreated. And even when their presence is recognized, a therapeutic program may not be initiated because of our pessimistic views of the treatment potential of the aged.

The treatment potential for an aged person suffering with affective disorder is actually quite substantial, especially as compared to the organically impaired brain syndrome patient. To miss this potential may be to unnecessarily prolong illness, and worse, to invite brain damage through physical neglect.

Help for the depressed patient is possible if we begin with the recognition that the behavior is not random or accidental but is an expression of the patient's search for relief from suffering. There are specific therapeutic agents which can be helpful. Most important is the fact that the staff/patient relationship can be supportive, reassuring and may decrease feelings of helplessness in the patient. The promise of care and comfort implied by the presence of the staff is a source of support for the patient who feels despair. The allocation of staff time to his care evidences to him that he is considered worth an investment of time and energy; this decreases his feelings of unworthiness and of futility.

The depressed patient must recognize we are trying to help, we are "involved"; otherwise our inaction drives the patient to continue this inefficient, unconstructive pattern of behavior which we call depression, and which is the means by which he is searching for our aid and support.

Session XI

Depression (Continued)

Dr. Goldfarb: The treatment of the depressive disorder requires first a medical evaluation. Physical decline and depression may coexist. Illness and infirmity may have a causal relation to depressed feelings. They constitute loss of resources for adequate functioning, which leads to feelings of helplessness. Depression in turn aggravates and exaggerates illness and impairment with a resultant "vicious cycle."

An initial treatment plan is often suggested by the results of medical examination. Diminished hearing can be helped with hearing aids. Dentistry can relieve pain, improve the patient's appearance, and extend the number and variety of foods the individual can eat. Surgery may be in order: men with a prostate condition, which interferes with their accustomed activities, can be helped surgically. Hemorrhoids, uterine prolapse, cystocele are examples of health problems, common among old people, which are considered quite "minor" but which may seriously limit the individual's ability to manage his daily routine and get about easily. Surgery often can remove the limitation and enable the aged person to maintain his accustomed activities. Lost limbs can be replaced by prostheses, and physiatric technicians can teach compensatory mechanisms to patients.

You know from the medical program here in the Home about the improvements in health status which can be achieved when comprehensive diagnostic and treatment services are fully utilized. And often—particularly when physical decline has triggered a depressive reaction—improvement in physical health status is accompanied by an easing of the depression and by improved emotional health.

Even if the psychiatric disorder is not so immediately remedied, the attack on the physical health problems may still be of therapeutic benefit in the treatment of the depression. As several of you pointed out earlier, the depressed person is frequently immobilized by his feelings of helplessness. Treatment of his medical problems decreases his helpless feelings. Initiation of treatment signifies that help has been gained and is at hand.

Pharmacological treatment can influence mood. There are a number of useful antidepressant drugs. Electroshock is sometimes indicated. It is used less frequently than it was before we had the array of pharmacological methods now available. It is still of help when depression does not respond to medicines, when medication is contraindicated by cardiac, gastro-intestinal or allergic conditions, and when there is resistance to drug taking or when the patient's condition indicates haste is required.

Social Worker: What about psychotherapy? Isn't it effective with some cases of depression among the aged?

Chaplain: But it takes so long, doesn't it? You're not thinking of psychoanalytic sessions over a period of several years, are you?

Dr. Goldfarb: No; psychotherapy with the aged can be brief. We don't usually think of the "old fashioned" psychoanalytic approach. Yet, it may be of an "insight developing" or "character changing" type. More frequently with aged patients we use

the personal relationship to provide reassurance and support. This can be very effective with patients who are in danger of being overwhelmed by fearful and angry feelings.

Occupational Therapist: Participation in both discussion and activities groups seems to help many of our depressed patients, Dr. Goldfarb. They talk about "occupational therapy" or the "sheltered workshop" or "arts and crafts" as being their "therapy." Many of these patients are the ones who were always busy, and inactivity itself is destructive to their self-esteem.

Psychologist: In our analysis of the sheltered workshop workers, a number of anxious and depressed patients said that shop was therapeutic because they were able to lose themselves in their work and stop thinking the thoughts that distress them. The respite the shop gave them was welcome in itself. And, of course, we can hope that the respite might be both a *rest* and a restorative, refreshing interval, from which they might return to the unit with more energy available to them.

Physical Therapist: One treatment benefit which depressed patients can get from their group participation is in their relationships with the staff workers or the other group members. Think of Mr. Gerson, for instance: On the unit he just sat and rarely spoke or even responded to anyone. But in both physical therapy and the workshop he worked productively; and in both, there was one staff member who was able to connect to him.

Dr. Goldfarb: This is a very important element in the treatment of depression. You know how often we find the patient seeking a protective, nurturing person and milieu on which he, in his helplessness, can depend. You remember Mrs. Stone and her search, for example. Frequently the provision of a surrogate—a staff person who can represent to the depressed patient the beloved person who did care for her—often this provision is surprisingly effective in treatment of depression. And as you point out, the patient may not find this significant figure on his unit, but can find him in the occupational therapist or sheltered workshop staff. This may be because he can only feel he has found the surrogate parent in a situation in which he has performed so as to win him—that is, earn his favor.

Chaplain: The relationships between residents seem to be like the relationships they had with parents or siblings or mates. Their "friendships" certainly seem to be antidotes to depression.

Nurse: Some of these relationships are probably closer and more nurturing than what the patients used to have with their parents, their siblings, or their mates.

Administrator: The number of treatment approaches available should make us more optimistic about depressed patients. Neglect of this disorder is hard to understand or defend.

Can we spend some time on a special group of the depressed—those who threaten or actually try suicide. What do we need to know about these patients? We've always assumed, I think, that potentially suicidal patients are from the most severely depressed group. Are we right about this? What kind of suicide prevention program should we have?

Dr. Goldfarb: Depression and suicide are related. Also many "accidents" are merely disguised suicide attempts. As you know, the accident and suicide rate is extremely high among the aged.

The rate of accidents and especially of suicides is low, however, for the institutionalized aged population. Why is there a difference between the institution and the noninstitution rate?

Physical Therapist: I know that the rate for men is much higher than for women in the over 65 age group. And I assume that this reflects the greater stress in old age for the man. For example, women are not abruptly retired from their homemaker role as are men from the worker role. And even if the old woman is no longer maintaining her own home, as our residents and patients aren't, she still is able to knit or crochet or do other things which help her hold onto her role.

Dr. Goldfarb: Yes, the suicide rate for men over 65 is considerably higher than it is for females. This may be a reflection of the special stresses the aged man faces. Retirement for the man in most cases means an abrupt and complete loss of role. He is no longer a worker. Women, on the other hand, face a much more gradual process of change in role if they are homemakers. Also women who work can often continue working long after retirement age. Consider, for example, the number of nurses well into their 70's who still work—albeit part-time and in jobs tailored to their declining strengths.

In an institution, female residents find ways to make themselves useful as "feeders" for infirmary patients, as receptionists, hostesses at parties—activities more acceptable to and appropriate for women than for men. In general, women in their old age seem to have an easier time maintaining their roles as giving, *do*-ing people, while at the same time getting the care and respect they need.

But old men are generally physically sicker than old women. This is often a reason why they want to end their lives. When I say sicker, I mean that the incidence of malignancy, cardiovascular diseases, and other diseases of old age come upon men earlier than women.

Administrator: You've talked about reasons for suicide among the aged—loss of employment and the worker role for one, serious illness for another. Are the reasons different for the aged person as compared with the college student for example?

Dr. Goldfarb: There are probably differences related to age. However, in young persons just as in elderly persons, failures in establishing good relationships that are gratifying, protective, and yield a sense of security are important reasons for many suicidal attempts. In old age loss of employment, loss of mate, isolation, alcoholism, poverty, and illness are related to suicide. Conversely, suicide is relatively infrequent in old age homes that are well staffed, provide recreational and avocational opportunities, which encourage and make possible social relations, treat illness and provide food and lodging.

One caution: our statistics tell us only about *reported, successful* suicide attempts. Many suicides are not recorded as such, either deliberately in order to protect the feelings and reputation of the family or because the facts of what has occurred are not known or not understood. Many deaths recorded as accidental are, in fact, suicides. It is possible that some accidental deaths are mistaken for suicides; this may occur when the patient is brain damaged.

Whatever the age of a suicidal person, and whatever desires for riddance, revenge, reproach, restitution, or forgiveness, self-punitive anger with onself is probably present.

Social Worker: Dr. Goldfarb, you say that along with the anger turned against oneself, there is also a reproachful attitude toward others who should have seen how troubled

the person was and done something about it. I think we frequently see and hear expressions of this attitude among our residents and patients.

But there are people who say, "I have nothing to live for. No one can help me; no one cares about me. I want to die." Is this a reproach for our failure to help, *or is it a call for help?*

Nurse: We hear patients say that kind of thing every day. Sometimes it seems as if they're threatening us. They say, "If I don't get the room I want, I'll kill myself" or "I can't stand another day with that woman as my roommate. You've got to move her, or I'll kill myself."

How should we respond to these threats? We can't always meet the patient's demand. And when the demands are met, there are often further demands.

Others seem to use suicidal threats in a different way. Is it an attention getter? It's hard to know when a threat should be taken seriously.

Chaplain: I've heard that people who talk about committing suicide are not the ones we should worry about — that people who are really intent on doing away with themselves usually don't talk about it.

Dr. Goldfarb: Many people believe this to be true, but I doubt that any such generalization can be made. Sometimes a threat or attempt to commit suicide brings the desired result and further threats or attempts are no longer necessary. Here in the Home, for example, you have patients with decreased resources and with little hope of regaining what was lost. A man is sick; he's been forced to enter the institution; he's lost his personal and psychological resources and his ability to earn a living and to remain in his home. All this occurs in a person who already has psychological and emotional problems which make it difficult for him to handle the everyday routine and demands made upon him in the Home. He loses his feelings of worth, his confidence ebbs and he feels there is no purpose, no reason for living.

All this is felt as helplessness. To this he reacts with shame for not being able to manage for himself. And he may react with guilt—that somehow this is his own fault and that he is not performing as he should. He becomes frightened by his helplessness, he tries to find assistance, and his approach to this is to say, "Look, you're supposed to be helping me. Why aren't you doing this? I can't do it alone, and I can't stand feeling like this. I've got to get rid of these terrible feelings, and if you don't help me, there's no hope for me."

Now, if we understand what is behind the patient's words or attempts, we respond to the plea. We show our concern and evidence willingness to see whether we can provide the help the patient is asking for. He is not forced then to exaggerated dramatic expressions of anger at himself or to others. Threats or unsuccessful attempts are not evidence of lack of intent to commit suicide. Only when words or actions achieve the responses desired do these threats subside. All threats must therefore be considered serious. However, just as the demand for a different room or roommate or a different diet may publicize a wish for a more supportive and interested personal milieu, so the threat of suicide may be symbolic of the intensity of the person's feelings. Hence the person's tendency to be dramatic must be evaluated. When the patient's tendencies to use dramatic, emphatic figures of speech are taken into account some seemingly suicidal threats can be recognized as hyperboles, as exaggeration to make a point clear. But we should never discount the seriousness of the threat until the point has been grasped, and the patient knows it's understood.

Session XII

Suicide: The Final Depression

Dr. Goldfarb: Last week we talked about patients who say things like, "I can't stand this pain; I want to die;" or "I'm old and alone and life just isn't worth living anymore." You had questions about how we are to respond to statements like these. How can you know when they should be taken as serious statements of intent, and when they can be treated somewhat less seriously?

Perhaps we can arrange threats on a continuum—at one end of the spectrum is a desire for life; at the other end is a desire for death. At the one end are the least worrisome or threatening signals or clues; at the other end are statements or behavior which seem most serious, most predictive of a suicide attempt.

Social Work Supervisor: Let me give you two statements I've heard in the last several weeks from patients, and see where they should be placed. One lady said to me, "It's gotten so that life's not really worth living; it's not worth the trouble anymore." Then there's Mr. Hausen who says, "What I want is to die; I wish I were dead and buried, already."

Dr. Goldfarb: Do you think that we should worry equally about these two people? Do they have the same attitudes toward life?

Social Work Supervisor: No, they don't seem to have the same attitude, but I don't understand quite what the difference is.

Psychologist: One thing may be, that with the first statement you have a handle—something you can work on—you could ask the lady, "What do you think *would* make life worth living?"

Dr. Goldfarb: Perhaps the fact that the patient gives you that handle is a clue. You would place him on the interest in living end of the spectrum. The man who says, "I want to die" gives you nothing to work with him on, so we might place him closer to the want to die side, and the man who says, "I want to die; I'm going to see that I do" you would take most seriously of all.

There is a range of statements and attitudes which connote increasing danger of suicide, beginning with "This is no life," "Who wants to live like this?" "If I were taken, it would be better, everyone would be better off," "I wouldn't do anything to cause it, but I would welcome death," and then to "True, I might do something if I had the courage," to "I would if it weren't for the children, grandchildren, etc. I wouldn't want to hurt them," to "If I knew how, I would do it," and finally to "I consider suicide frequently. The idea keeps coming to my mind, and I think of how to do it."

All patients making such statements can be helped by way of a relationship. Of the man who has given us "the handle" you can ask, "What would make life worth living?" and in this way lead into conversation that can help him to ventilate his anger, express his fears, and form a sustaining relationship.

His answer might be, "I'd like to live if I could have treatment for my arthritis; with such pain, it's not worth living." This may be true yet it symbolizes also his need for relief from suffering of a more general kind; his anger about limitation of mobility or function and his fear of having more pain and less self-sufficiency, and perhaps death.

Physical Therapist: If people could choose a painless death, I wonder how many of our residents would really choose to live.

Social Worker: Most of them would, I think. When they're in the infirmary and so sick, they fight with everything they have to get better. I think their holding to life is so firmly embedded in their culture and background that no matter what, they can't think of doing away with themselves.

Dr. Goldfarb: I think that you're probably right that there are cultural attitudes which plant people pretty firmly on one side of the spectrum or the other. For instance, suicide rates in Japan are very high, and I would say that cultural factors account for this, at least in a general sense.

And I would agree that the cultural attitudes of our residents and patients are different from those of the Japanese, and do tend to place our people on the life side of the spectrum. But there are individual differences, and we do have to look at the clues and signals in individual behavior which should alert us to high risk patients—that is, patients who may be seriously considering suicide.

Administrator: Let's go back to our patient who says he doesn't want to go on living, because he can't stand the pain of his arthritis on a realistic basis. I assume that one step would be to see if there's anything that can be done to relieve the pain. But assuming that we've done everything we can, where do we go from there?

Dr. Goldfarb: Approach to the real situation is good and necessary while we also take note of and are guided by the symbolic value of the message. Our concern and action, plus the actual relief we give him, we hope will lead him to feel, "Well, things are a little better. I guess I can stand it for a while longer." We have to help him toward more interest in living.

A patient whose pain is irremediable or who subjectively feels that this is so may say, "Life isn't worth living, the pain is so bad."

Psychologist: But, Dr. Goldfarb, he is not necessarily saying, "Therefore, I am going to take my life." As you noted, he says something like, "I wish I could die," or "If only God would take me."

Chaplain: This goes back to the culture of our people, doesn't it? The patient is saying that the decision is in God's hands, and that the only thing he can do is pray to God to release him from his misery.

Dr. Goldfarb: Yes, what you're talking about is compliance, isn't it? That is the degree to which people act in compliance with the cultural imperatives which impinge on them. Yet there are individual differences here, and this is what we want to get at.

I think our psychologist is correct in assuming that when the patient says, "If only God would take me," if we asked him, "Would you yourself do anything?" he would probably say, "No, that's in God's hands."

Social Worker: Or he might answer, "I would, if it weren't for the children. I wouldn't hurt them this way."

Dr. Goldfarb: Yes, many of our patients might answer in these terms. In either case, we could place such patients still on the life side of the continuum, perhaps closer to the

middle or dividing line between life and death. Closer because these patients are signaling us that the only thing which is holding them to life is their compliance with the commands in their culture or with the wishes of their families.

Social Work Supervisor: We have a man in the Home now—Mr. Weiss—about whom I'm very worried, Dr. Goldfarb. He is a religious man, so he is complying with the tenets of his religion which say that human life is sacred, and suicide is a sin. But at the same time, he is going more and more into a deep depression, and I'm not sure that his religious beliefs will win out in a fight against his desperation.

Chaplain: I know Mr. Weiss very well, and I know that he will not commit suicide. He's just not the type.

Dr. Goldfarb: What do you mean not the type?

Chaplain: I don't know—it's an observation, a feeling that I have. This man is not capable of such an act. All he wants is attention and recognition. He feels frustrated because he is no longer able to play the piano or work in the shop, so he feels that people are no longer paying him the attention that is his due. I may see him twice during the day, and then the third time I come, he says, "I'm so unhappy. There's nothing left for me. I should be dead."

Administrator: What about his family? Do they visit him?

Nurse: That's part of the problem, I think. I gather that he and his wife had a difficult marriage and that she finally divorced him 10 or 15 years before he entered the Home. His daughter lives in California, and although she writes to Mr. Weiss frequently, to my knowledge, she's never come back to New York to visit him. And his son who lives in Westchester rarely comes or calls. The son's wife left him several years ago, and he's obviously got his own problems, some of which, I think, he blames on his father. So Mr. Weiss really has no one.

Social Worker: Except us, here in the Home. And this is why I think he's so desperate. His failing eyesight and general weakened condition mean that he can't do the things which won him a place in the Home, like playing the piano and being such a good shop worker.

Dr. Goldfarb: I'm interested in your use of the word desperate, because I generally see suicide as an act of desperation. Sometimes it's a calculated act and sometimes impulsive in the face of seemingly unresolvable problems. Particularly if there is no social recourse for the problems and no individual to whom the patient can turn, and who will understand. It is this desperation and the feeling that there are no alternatives—no way out of the trap—which I see as the common denominator in all suicides.

Social Work Supervisor: So in Mr. Weiss' case, we do have clues or signals which we should take seriously, don't you think? Because he really doesn't feel he has anything to live for—no sources of gratification left open to him.

Dr. Goldfarb: Does he have brain syndrome?

Nurse: I would say if there is any brain syndrome, it's mild.

Dr. Goldfarb: And what about the staff who have acted as surrogates for the wife and son who don't love him and the daughter who's too far away? Is it possible for the staff of this Home to supply his need for love and activities to take the place of those he can no longer engage in?

Group Activities Worker: I guess that would be me, and the social work supervisor, and his own social worker, and the chaplain. We all visit him daily but nothing seems enough. His need seems insatiable.

Dr. Goldfarb: But I get the impression he is still reaching out to you. He's still sociable in the sense of wanting people around. He still talks to people in a relevant fashion and with emotional content, albeit depressed.

Social Work Supervisor: Yes, this is true, yet I think he is telling us that we really have nothing more to offer him. Now with the loss of his eyesight and his strength, he feels that we are lost to him, too, and that there is nothing we can do to help him.

Nurse: Yet he is afraid to die. When he wakes during the night, he's always frightened and wants someone to stay with him.

Dr. Goldfarb: Fear of dying at times leads people to act to rid themselves of the fear. They choose their time rather than being forced to wait for it. Are there any psychiatric notes on Mr. Weiss?

Social Work Supervisor: Yes, Dr. S. saw him. You know Mr. Weiss has been a resident of the Home for 11 years, and he has had periods of acute depression before this. Dr. S. described him as immature, dependent, narcissistic and subject to cyclical depressive states. He is receiving antidepressant medications. Usually when Mr. Weiss is acutely depressed, he withdraws from his activities, and customarily Dr. S. has recommended that staff reach out to him and try to encourage contact in the programs from which he derives satisfaction. Now he isn't physically well enough.

Chaplain: Also, at present he's very jealous of his roommate, Mr. Allen. Mr. Allen has so many friends, and they visit him all the time, and one day Mr. Weiss said to me, "Why does everyone come to him? I'm sicker than he is."

Dr. Goldfarb: Envy of others is common with depression. A depressed person envies others because they don't seem to be depressed and suffering. An avoidance of the "luckier one" is one reason for their withdrawal. There does not seem to be a high risk of Mr. Weiss' committing suicide, although he is, obviously depressed. If his pleas for attention and affection were to go unheeded, he might move farther on our continuum toward desiring death. I think it's very important that you who have the closest relationships with Mr. Weiss recognize that you are, in fact, surrogates for his wife and children. When he is fearful during the night, he must be reassured and comforted, for it is in those early morning hours—"the dark times of the human soul"—that suicide is most frequent.

Administrator: Obviously what you're saying is that we must not look contemptuously upon his actions as "attention getting devices." He must get the humane attention that he's asking for in disguised and elaborate ways.

Psychologist: I was thinking about the difference between Mr. Weiss and Mr. Smith who did commit suicide 2 years ago. Using Dr. Goldfarb's continuum, there were signs that Mr. Smith had moved to the death side. He was religious, too, but his frustration about his physical decline and his anger at his children for putting him here and for not seeming to understand how terrible being here and being sick were for him—these were the things which pushed him away from his religion and the life side of the continuum.

Dr. Goldfarb: What signals were there?

Chaplain: He pushed people away from him, at first, in anger: "Go away, there's nothing you can do for me." And then in the weeks just before his suicide, he often simply turned away from staff who greeted him or tried to talk to him.

Social Work Supervisor: Yes, that's true. I often felt that I was intruding on his privacy, and that he resented my speaking to him.

Dr. Goldfarb: The signals in this case were his anger at other people and his statement that no one could help him?

Social Worker: There was more than that, Dr. Goldfarb. He committed suicide sometime between 4:30 and 5:00 A.M., Saturday morning—in those dark hours you were talking about. He had had a prostectomy several months before, and he was apparently still experiencing a lot of pain. He had had a stroke several years ago—that was why he came into the Home as an infirmary patient. He really had made a remarkable recovery, regaining most of the use of his arms and legs, though he did have to use a walker.

But the recovery was physical only, in a way—he never could accept his need to be in the infirmary, and always said he was only half a man. And with the prostectomy (he had had months of pain), he felt keenly the indignity of the medical and nursing care that his condition required.

When he was brought back from the hospital, he kept saying it was all over for him and spoke very bitterly about his children. He blamed them for not caring for him in their own homes.

Administrator: Yet, I know his son and daughter well. They say he was never a loving father; they describe him as cold and punishing. I remember at the time they brought him to the Home he was kicking up a ruckus, and his daughter said to me that her father had no right to expect them to take care of him in their homes—he hadn't earned that kind of devotion.

Social Worker: Yet he did seem to feel he deserved better from them than he got, but even when they came to visit him—the son more than the daughter—he didn't try to be pleasant, but instead complained and berated them. That was up to the time of this last operation. Then he turned away from them as he did from us.

The day before he did it, the nurse called me because Mr. Smith seemed so down. I talked to him, and because he seemed so bitter about his son s not visiting that day, I phoned his son who said to tell Mr. Smith that he'd be here Sunday. I also arranged for Dr. S. to see him on Monday.

When I went back to see him just before I left Friday afternoon, I told him that his son would be here Sunday and that he was worried that Mr. Smith was feeling so blue. Mr. Smith just laughed—not really a laugh, a sort of bitter grunt, really—and he said that his son needn't bother to come. It was too late now. I stayed, and tried to get Mr. Smith to talk, but he just turned away, and finally he asked me to leave. Before I left I alerted the doctor and the head nurse on the floor.

Nurse: Yes, we noted on Mr. Smith's chart what he had said to the social worker, and we kept a close watch on him that night. He was in a private room in the infirmary and as we looked back on what happened, it seemed to us that we should have moved him to one of the observation rooms on the Maximum Care Unit. But we didn't—I must say it never occurred to me that with his bad leg and everything, he could get the window open and get himself through it.

Director of Nursing: No, we thought the every half hour checks would suffice; I remember thinking about moving him to one of the observation rooms, but you know he committed suicide in January and we were just in the midst of the height of our winter upper respiratory cases and all the Maximum Care Unit beds were full. Hindsight says we could have moved someone—oh, how I wish we had.

Chaplain: Yet, I must say I saw Mr. Smith at about 9:00 Friday evening. He was, as you all have said, bitter and unwilling to talk very much. Yet he didn't seem any worse than he had been before, and I would not have believed that he would do this thing.

Dr. Goldfarb: I think you probably did all that could be done. Hindsight, unfortunately is better than foresight. Yet hindsight at times deceives us because the clues were not really there to be helpful predictors. In a sense his death hinged on the fact he was in a tall building. You did respond; you called his son; you did make ½ hour checks on him. You might have put an aide in his room with him, but even that might have only deferred his act. As you think about what kind of a person he was and what he said and did, you can see that he was all the way over to the death side of the continuum. He wasn't saying, "Life would be worth living if. . . ." As a matter of fact, he was not discussing life anymore. He told his social worker it was too late. You see in Mr. Smith the rage and anger that we have discussed, and also the desperation. His act of violence was clearly a planned one, and his desperation came from his seeing himself as only half a man and not one who—for whatever the reasons—could count on his children to love or respect him.

Administrator: In a sense, Dr. Goldfarb, wasn't Mr. Smith's suicide a kind of act of compliance with the unspoken wishes of his children? Often I think the message our residents get when their children bring them here is that it is time for them to die. Children use the words, "We had to put mother away" (to refer to the mother's admission to the Home), and these words seem very near to death words to me.

This was particularly the case with Mr. Smith who never admitted that his physical condition made infirmary care necessary and who always thought his children should have maintained him in their homes. And the message was made even clearer by the children's obvious unwillingness to have Mr. Smith with them, regardless of his health situation.

Dr. Goldfarb: Yes, I think you are probably right. In any event, there was no possibility that Mr. Smith could get from his children the loving respect that he wanted, nor apparently could he accept staff surrogates, as Mr. Weiss has.

Administrator: I think from this discussion of suicide that we need to see depressed patients as persons who need planned care and attention based on understanding that they are still holding onto life and reaching out for sources of gratification and love. Suicides in the Home are rare and may become even rarer if we learn how to deal with those who turn away from us, who appear to be turning away from life itself.

Session XIII

The Optimal Environment for the Patient with Brain Syndrome

Dr. Goldfarb: What kind of physical environment and daily routine should a long-term care institution provide for severely impaired brain syndrome patients? Can those of you with many such patients tell us what your units are like?

Nurse: I think that Unit 7 is not unlike the rest of the infirmary. I've been on the unit for 3 years, and at times I feel angry at staff who avoid coming there because they think it's some kind of "Snake Pit." When I say it's like the other units I mean there are severe brain syndrome patients scattered all through the institution. The only difference is that *all* of our patients have brain syndrome. And in a way they seem set aside.

Occupational Therapist: Yes, it seems to me that the better patients get more programmed care, more staff, more activities, more volunteer services and Unit 7 gets what's left over. I know that we can use the activity programs more easily in the better units because the patients are better oriented and seem to get more benefit and pleasure from the programs. But even our considerably mentally impaired enjoy music, and some work well in the sheltered workshop or occupational therapy; others enjoy bingo even though staff has to help them play.

Psychologist: Is part of the problem that we tend to lump all severe brain syndrome patients together? We think of Unit 7 as being a place where the very old lie in bed or sit in their chairs in front of the TV all day whether the set is on or not. We forget that they differ from each other and need different kinds of activities and routines and care if they are not to subside into apathy. Apathy, as you have emphasized, is a signal of distress, an appeal for aid.

Dr. Goldfarb: In the study of your sheltered workshop for the severe brain syndrome patients, you learned some very interesting things about these differences among patients and the efficacy of combatting apathy by providing social relationships. And incidentally, you pointed up a weakness in the predictive value of the testing procedures we use with brain syndrome patients.

While our tests do determine the presence and severity of brain syndrome, they give us no picture of the resources—the assets—which the patient still may have at his command. Additional psychiatric and physical health status evaluations are necessary to measure the person's physical energy, his strengths and his motivation to remain active or sociable. While we must know the patient's limits we must be most interested in his assets.

Nurse: There certainly are differences among patients in energy and sociability. For example, some patients with brain syndrome are physically and socially active. Some physically sick and debilitated brain syndrome patients are out of bed for only a few hours a day and need help in getting dressed, toileting, and eating. They sleep a lot and don't talk very much to anyone. In occupational therapy their activity is minimal, and they prefer to leave quickly.

Psychologist: Yet we have patients with severe brain syndrome, who work in the sheltered workshop and who go to occupational therapy as well, who are energetic and physically strong. Perhaps it helps them to keep busy; they may need a very different kind of environment than the low energy, physically ill, or infirm do.

Social Worker: On the other hand the energetic, active brain syndrome patients are most often the ones who create the most serious management and interpersonal problems. By contrast it is usually the inactive and docile people with severe brain syndrome who can live with less impaired or non-brain syndrome patients.

The energetic, severely impaired brain syndrome patients are the ones who are "all over the place." They often get into loud arguments with other patients or staff. Other patients are afraid of them or complain about the noise and unpleasantness they create. So we transfer them to Unit 7 because there's more staff there to supervise them, to protect them and other patients from them if need be. Also, other equally impaired but less energetic brain syndrome patients are less troubled by them than are more intact patients. The apathetic, inactive patients on Unit 7 rarely get in the way of the active ones; usually the only friction between Unit 7 patients is between two high energy ones.

While there are differences between patients on Unit 7, and they therefore have differing needs, it's better for them and for our other patients if we set aside special units for the severely impaired.

Dr. Goldfarb: This may be true. The answer may be in designing an environment for brain syndrome patients which takes into account their differences. Can we specify some of the items in such an environment?

From what we know about persons with brain syndrome the appropriate environment must be protective, and supportive. Regardless of their energy level, these are patients who can't be trusted to stay home alone. They are people who may wander into a busy street; walk off even well-protected stairwells; who may turn on the gas and forget to light it; who will leave water boiling in a kettle until the kettle bottom burns out; who lose their way even in their own homes.

They have come to an institution which has a staff to supervise their activities because they couldn't live at home anymore and need a physical environment away from busy streets. They need an uncomplicated facility, which maximizes their ability to learn their way about: from their room to the dining room, the shop, the occupational therapy room, the lavatories. They need staff with time, patience, and skill to help them in many ways. They need supportive persons, if they are to live, who see to it that they eat, bathe, have toileted, and go to bed.

Now, all of this is not required in the other units. The more cerebrally intact and physically more functionally able old people would find this stultifying, too circumscribed, too care-oriented, not sufficiently interesting or challenging a way of life.

Administrator: I've been struck by how much better many of our severely impaired patients do on Unit 7 than they were able to do on units where there are more intact patients and more activity. We talked in earlier sessions about residents or patients whose explosive behavior signaled inability to cope with a variety of stimuli and demands from their environment. Can we say that the segregated unit is better for the severely impaired because we design it so that there are fewer and less complex stimuli?

Dr. Goldfarb: I agree we've too often assumed that contact with more intact patients is beneficial to the impaired patients, that this contact keeps impaired patients from further

deterioration. There is really little evidence to sustain this assumption. On the contrary, the severely impaired patient is likely to respond to complex stimuli by "exploding" or by withdrawal from the too demanding environment. But this does not mean that there should be no stimuli or activity in a protective environment. It simply means planned, structured, "enlivening" and not threatening programs.

Nurse: In our experience, Dr. Goldfarb, most of the connections have to be between staff and patients; it's rare that the severely impaired patients initiate or sustain conversations among themselves. It's only when staff are present that such interrelationships can be fostered, and usually if staff leaves the room, the conversations cease.

Dr. Goldfarb: This is consistent with my experience. I would add that the staff effort required to get patients out of bed, dressed, and seated near each other is an important part of humane care of these patients, even though the return on these efforts seems very small. Also, single rooms in units housing severely impaired patients are probably not advisable. The reasons are practical. First, we must encourage effective and efficient use of nursing personnel. Also, the presence of others is a reassurance and comfort, because even the most primitive awareness of others in the environment, even the limited responsivity to others, probably represents a source of pleasure for the patients.

Nurse: In relation to nursing staff patterns, we have a lower nurse-patient ratio on Unit 7 than we do on our units where patients are critically ill, and lower also than on the units where there are more intact patients. On the other hand the aide-patient ratio is the highest on Unit 7, because these patients require so much help in dressing, eating, toileting.

Occupational Therapist: Our staffing pattern is much the same. We find that the attention span of these patients is usually shorter than that of more intact patients, and also that they are less able to tolerate waiting for the staff person's attention. Some "explode" if they have to wait—I guess these are the high energy patients. The others just stop working and often doze off. Also it takes more staff time to teach the severely impaired patients how to do the tasks involved in the various activities.

Another thing about program activities in general: The activities room, I think, should be located in the unit itself, as our Unit 7 occupational therapy room is. Most of the patients learn the way from their rooms to occupational therapy, but when they must leave the unit, they usually need an escort. Also there seems to be an emotional factor involved for some of them. Even with an escort, some of our patients seem fearful about leaving the unit, so whenever a program is scheduled off the unit, attendance always drops.

Psychologist: Some of the things we've done in our infirmary—not just on Unit 7—are important in making the environment as supportive as possible. The big, brightly colored floor numbers which are placed on each floor so that you see them as the elevator door opens is one example. Also each floor is identified by a different color.

In the workshop, we've put up a number of large calendars which give the day and date to help people keep track of time. Large clocks serve the same purpose.

Dr. Goldfarb: Another finding from the research you have done in connection with the sheltered workshop program is important. When you established the work program in your infirmary section, I was not optimistic about chances for success. I thought that few severely impaired brain syndrome patients would be attracted to the program and I doubted that even they would be able to work productively.

Your reports and my observations of the program proved me wrong on both counts. Attendance and participation records provide evidence that severely impaired patients will come on a regular basis to the work program, and that barring illness, their participation can be sustained over long periods of time.

Of greater significance is the finding that, given training of sufficient duration tailored to the remaining resources, severely impaired patients can be taught work tasks required for jobs in the shop. True, their rate of production is lower than that of more cerebrally intact resident workers.

Administrator: In the past the diagnosis of mental impairment due to organic losses or malfunction led us to a pessimistic view of the patient. We assumed there was nothing to look forward to except further decline and deterioration, serious management problems, and misery and unhappiness for the patient and his family, with death as a relief. As our discussion today indicates and the workshop experience demonstrates, we now have more optimistic views.

Dr. Goldfarb: Yes. This point provides the best summation and ending for our series of discussions. Lost brain cells cannot be replaced, and lost capabilities may not be restored. Yet the severely impaired need not be doomed to a vegetable-like existence. Most of them have resources and capabilities which they can use pleasurably, with dignity and confidence if we have the knowledge, skill, and patience to help them use their remaining assets.

We know that the pain and misery which is the fate of thousands of the mentally impaired aged among us can be avoided or ameliorated. What is required is humane, compassionate care in a milieu which does not impose excessive demands but rather supports and nurtures. This should be our task and our goal.

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